

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11495

11480

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lynchburg</u>	
c. LENGTH OF STAY IN lb <u>70 days</u>		d. STREET ADDRESS <u>3800 Sheringham Place</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Andrew Abernathy Sr.</u>		4. DATE OF DEATH Month Day Year <u>October 5 19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>81</u> yrs.
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u>		10. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Polk Abernathy</u>		14. MOTHER'S MAIDEN NAME <u>Annie Lucy Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>(S) Robert A. Abernathy Jr., Richards, Va.</u>	
17. INFORMANT <u>(S) Robert A. Abernathy Jr., Richards, Va.</u>		Address <u>110 Tazewell Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, primary unknown</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (it (this hospital) attended the deceased from <u>July 27, 1961</u> to <u>October 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>October 5, 1961</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William P. Urschel</u> M.D.		22b. DATE SIGNED <u>October 6, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM P. URSCHEL, LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Shipment 7 Oct 1961</u>		23b. DATE THEREOF <u>7 Oct 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Maplewood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pulaski Tennessee</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 10 '61</u>	
ADDRESS <u>Funeral Home Bethesda, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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CENTROGRAPH

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Robert A. Kennedy

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11496

Item 1 Film G297 10/13/61 iwk

11481

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		g. STREET ADDRESS #2 Warmsey		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Milton Addison		4. DATE OF DEATH Oct. 5 1961		5. SEX Male	
6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/5 /96	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Robert H. Addison		14. MOTHER'S MAIDEN NAME Amanda Bowie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Son Vincent Addison Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Diabetes mellitus secondary to acute, obliterating arteriosclerosis (chronic)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) —			
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —		20g. (County) —		20h. (State) —	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.					
22a. SIGNATURE JOHN B. Umhau		22b. DATE 10/6/61			
22c. PHYSICIAN'S NAME (Type) JOHN B. Umhau		22d. ADDRESS 8805 Conn. Ave. Chevy Chase 15 Md.			
23a. BURIAL, CREMATION, REMAINS (Specify) Burial		23b. DATE THEREOF 10/9/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion.,	
23d. LOCATION (City, town or County) Mt. Zion, Md.		23e. (State) —			
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		24b. ADDRESS Rockville Md.		25a. REC'D BY REGISTRAR OCT 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "Laboratory" and "Report" are faintly visible.]

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Form Pages 1, 2, and 3 are to be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
11497											
11482											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>3 yrs.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>36 Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10819 Hobson St</u>				d. STREET ADDRESS <u>10819 Hobson St</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Fannie</u>				First <u>Fannie</u> Middle <u>Albert</u> Last <u>Albert</u>				4. DATE OF DEATH <u>Oct 4 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-1896</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>				11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIMON SILVERMAN (Dec)</u>				14. MOTHER'S MAIDEN NAME <u>CELIA CHESLOCK (Dec)</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>				17. INFORMANT <u>Russel, Albert - Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>months</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>10-4-61</u>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHANT</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/5/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETH SHELMAN Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>CAP. HTS. MD.</u>					
23. FUNERAL DIRECTOR <u>Charles J. Russell</u>				ADDRESS <u>4217-9 Ave</u>				24a. REC'D BY REGISTRAR <u>OCT 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11498

CERTIFICATE OF DEATH

Item 2-Film 0300

11/15/61

11483

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland c. LENGTH OF STAY IN lb 46 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor Sanatorium				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington Washington d. STREET ADDRESS 3724 Davenport St., N.W. 4831 Flanders Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle E. Last Alexander			4. DATE OF DEATH Month October Day 31 Year 1961				
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24 - 1880		9. AGE (In years lost birthday) 81 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Orville Comstock				
14. MOTHER'S MAIDEN NAME Mary Frazier			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. None			17. INFORMANT Paul Alexander-son-same Address 4831 Flanders Ave. Kensington, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, acute 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerosis, generalised DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours 5 yrs +		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia, right, severe, with aphasia Aug 1961							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from _____ 19 51 to Oct 31 , 19 61 , that (I) was last saw the deceased alive on Oct 24 , 19 61 , and that death occurred at 4:45 M, from the causes and on the date stated above.					
22a. SIGNATURE Stewart Clapp		22b. DATE SIGNED Oct 31 1961		22c. PHYSICIAN'S NAME (Type) Stewart Clapp			
22d. ADDRESS 4740 Chevy Chase Dr Chevy Chase Md.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			
23d. LOCATION (City, town, or county) Suitland, Maryland		23e. (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR NOV 2 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

11499
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11484

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>✓</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CONGRESSIONAL MANOR SANITARIUM</i>				d. STREET ADDRESS <i>4500 Conn. Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lelia</i> Middle <i>M.</i> Last <i>Allen</i>				4. DATE OF DEATH Month <i>10</i> Day <i>6</i> Year <i>1961</i>			
5. SEX <i>fe</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 13, 1887</i>	
9. AGE (In years last birthday) <i>73</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edwin Markell</i>				14. MOTHER'S MAIDEN NAME <i>Lelia Michael</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>577-36-2064</i>		17. INFORMANT <i>MRS. JEAN ALLEN EID, SAME AS # 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X METASTATIC CARCINOMA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CARCINOMA BREAST</i> DUE TO (c) <i>8 YEARS</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 YEAR</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <i>1955</i> to <i>10/6</i> 19 <i>61</i> , that (I) (was) last saw the deceased alive on <i>10/4</i> 19 <i>61</i> , and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Wm. S. Detwiler</i>				22b. DATE SIGNED <i>10/6/61</i>		22c. PHYSICIAN'S NAME (Type) <i>Wm. S. DETWILER</i>	
22d. ADDRESS <i>1025-CONN. AVE. D.C.</i>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>				23b. DATE THEREOF <i>OCT. 7, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill CREMATORY</i>	
23d. LOCATION (City, town, or county) (State) <i>SUITLAND, Md.</i>				23e. LOCATION			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Sawicki's Sons</i>				24a. REC'D BY REGISTRAR DATE <i>OCT 10 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
24c. ADDRESS <i>1756 Pa Ave N.W.</i>				24d. ADDRESS			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11500

CERTIFICATE OF DEATH

11485

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>38 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> Baltimore b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4309 Miami Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Joseph</u> Last <u>Anson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 2, 1919</u>		9. AGE (In years last birthday) <u>41</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Lawrence M. Anson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bartek</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>				16. SOCIAL SECURITY NO. <u>203-05-1460</u>		17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO (b) <u>Infarction, cerebellum, part of cerebrum and upper spinal cord</u> DUE TO (c) <u>Chronic packy and leptomeningitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>					
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>August 31, 1961</u> , to <u>October 8, 1961</u> , that <u>10</u> (we) last saw the deceased alive on <u>October 8, 1961</u> , and that death occurred at <u>12:05 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>John E. Somers, M.D.</u>				22b. DATE SIGNED <u>10/8/61</u>				22c. PHYSICIAN'S NAME (Type) <u>John E. Somers, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens Cemetery</u>		23d. LOCATION (City, town or county) <u>Lehman Pa.</u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Greenworth Armacost</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Frank</u>				25b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

1122

STATE OF TEXAS

1100

M

County of ... State of Texas
I, the undersigned, Clerk of the County of ... State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the County of ... State of Texas.

Witness my hand and the seal of the County of ... State of Texas, this ... day of ... 19...
Clerk of the County of ... State of Texas

Attest:
My hand and the seal of the County of ... State of Texas, this ... day of ... 19...
Clerk of the County of ... State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11501

11486

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Col.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>20 Whittier St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Henry</u> First <u>(NAN)</u> Middle <u>Argent</u> Last		4. DATE OF DEATH <u>Oct.</u> Month <u>23</u> Day <u>1961</u> Year		9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proof reader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Office</u>		11. BIRTHPLACE (County & State, or foreign country) <u>England</u>			
13. FATHER'S NAME <u>Henry Argent</u>		14. MOTHER'S MAIDEN NAME <u>Alice Twillan</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-40-4629</u>		17. INFORMANT <u>Koop. Records</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Congestive failure</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>12 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>Oct 23</u> <u>1961</u> , to <u>Oct 23</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 23</u> <u>1961</u> , and that death occurred <u>1220 AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Raymond O. West</u>		22b. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>TAKOMA PARK, MD</u>			
22e. DATE SIGNED <u>10/23/61</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 26, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>			
23d. LOCATION (City, town or county) <u>Prince Georges County, Md.</u>		23e. (State) <u> </u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		24b. ADDRESS <u>254 Carroll St. NW D.C.</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 25 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11502

11487

1
FOR STATE
HEALTH DEPT.
M

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>322 Scott Drive</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY in 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rheba</u> Middle <u>Glenn</u> Last <u>Ay</u>				4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-1914</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk-Stenographer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				13. FATHER'S NAME <u>J. Nelson Gates</u>			
14. MOTHER'S MAIDEN NAME <u>Bessie F. Burke</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Mr. Edward L. Ay - 322 Scott Drive, Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> <u>AURICULAR FIBRILLATION</u> DUE TO (b) <u>PARTIAL OBSTRUCTION OF CARDIAC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>DUE TO CORONARY SINUS WITH BLOOD CLOT</u> INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>DAYS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-5-61</u>			
Address (Street, city, town, or county) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-9-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Balto. Maryland</u>	
23. FUNERAL DIRECTOR <u>Wm. J. Tickner & Sons</u>				24a. REC'D BY REGISTRAR <u>Balto. Md</u>			
24b. REGISTRAR'S SIGNATURE <u> </u>				DATE <u>OCT 9 '61</u>			



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The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11503

CERTIFICATE OF DEATH

11488

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN lb <u>50 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Kemptown</u> d. STREET ADDRESS <u>RFD # 1, Monrovia</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Edith Baker</u>		4. DATE OF DEATH Month Day Year <u>October 9 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1872</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. C. W. Kemp</u>		14. MOTHER'S MAIDEN NAME <u>Florence E. Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Edith Brown, Mt. Airy, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Sigmoid Colon</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized; congestive heart failure; anemia, secondary</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , to <u>October 9, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 8 1961</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>G. F. Meadors, M.D.</u>		22b. DATE SIGNED <u>10/9/61</u>	22c. PHYSICIAN'S NAME (Type) <u>G. F. Meadors, M.D.</u>
22d. ADDRESS <u>Damascus, Maryland</u>		22e. REC'D BY REGISTRAR <u>OCT 11 '61</u>	
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		22g. ADDRESS <u>Damascus, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 11, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Providence</u>
23d. LOCATION (City, town or county) <u>Kemtown, Md.</u>		23e. (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Molesworth</u>		24a. ADDRESS <u>Damascus, Md.</u>	

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Administrative General Hospital

Regel - Kammer

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Office

1. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 236, Film G299 11/6/61 iwk

11489

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural) c. LENGTH OF STAY IN lb 35 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1735 L Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Hartwick BAKER		4. DATE OF DEATH Month Oct. Day 29 Year 19 61	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9-6-98	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 63	
11. IF UNDER 24 HRS. Hours 63 Min. 63		11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Entertainer	
12. KIND OF BUSINESS OR INDUSTRY Novelty Shop		13. BIRTHPLACE (County & State, or foreign country) Illinois	
14. CITIZEN OF WHAT COUNTRY? USA		15. FATHER'S NAME Harry L. HARTWICK	
16. MOTHER'S MAIDEN NAME Margaret Rush		17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and dates of service) yes	
18. SOCIAL SECURITY NO. Unknown		19. INFORMANT (Brother) Maurice HARTWICK 14239 Young Ave. Detroit, Michigan	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Pneumonia DUE TO Lymphosarcoma (Lymphoidlastic) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO Lymphosarcoma (Lymphoidlastic) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2001		INTERVAL BETWEEN ONSET AND DEATH	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year 19 Hour e.m. p.m.		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that (this hospital) attended the deceased from 9-25 , 19 61 , to 10-29 , 19 61 , that (we) last saw the deceased alive on 10-29 , 19 61 , and that death occurred at 5:55 PM from the causes and on the date stated above.		28. SIGNATURE W. F. WARRENDER LT MC USN M.D.	
29. PHYSICIAN'S NAME (Type) W. F. WARRENDER LT MC USN		30. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland	
31. DATE 10-30-61		32. DATE SIGNED 10-30-61	
33. BURIAL, CREMATION, REMOVAL (Specify) Burial		34. DATE THEREOF 11/2/61	
35. NAME OF CEMETERY OR CREMATORY Arlington National		36. LOCATION (City, town or county) (State) Arlington, Virginia	
37. FUNERAL DIRECTOR'S SIGNATURE J.P. GAWLER FUNERAL HOME		38. ADDRESS 1756 Pa. Ave., N.W. Washington, D.C.	
39. REC'D BY REGISTRAR NOV 1 '61		40. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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11505
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
 11490

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>6 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>6821 Standish Drive</i>			
3. NAME OF DECEASED (Type or print) First <i>Didie</i> Middle <i>A.</i> Last <i>Bauer</i>				4. DATE OF DEATH Month <i>OCTOBER</i> Day <i>28</i> Year <i>19 61</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-6-16</i>	9. AGE (In years last birthday) <i>45</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>For Printing Office</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ass't. Unit Supv.</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Marcus D. Allred</i>				14. MOTHER'S MAIDEN NAME <i>Fannie V. Ray</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-----</i>		17. INFORMANT <i>Edward J. Bauer</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Coma</i> 157X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>Hepatic metastases</i> DUE TO (c) <i>Carcinoma of the Pancreas.</i>							INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 mos.</i> <i>unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus 2° to # 18(c)</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/23/61</i> to <i>10/28/61</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>10/23/61</i> , 19 <i>61</i> , and that death occurred on <i>10/28/61</i> at <i>5:40 AM</i> am the causes and on the date stated above.							
22a. SIGNATURE <i>Henry C. Scruggs</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>10/28/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>HENRY C. SCRUGGS</i>				22d. ADDRESS <i>7720 Wisconsin Ave Bethesda Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>NOV. 1, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ST. PAUL'S METHODIST CHURCH CEMETERY, HAMPTONVILLE, N. C.</i>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i> ADDRESS <i>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</i>				25a. REC'D BY REGISTRAR <i>OCT 31 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Charles L. Kraus</i>	

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(M)

11508

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH



[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11508

11491

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elizabeth City	
c. LENGTH OF STAY in 1b 11 days		d. STREET ADDRESS 104 Bell Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bryan Keith Baum		4. DATE OF DEATH Month Day Year October 3 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 20, 1956
9. AGE (In years last birthday) 5 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		11b. KIND OF BUSINESS OR INDUSTRY None	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. BIRTHPLACE (County & State, or foreign country) North Carolina	
13. FATHER'S NAME Hezekiah D. Baum		14. MOTHER'S MAIDEN NAME Mary J. Terrell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute Myelogenous Leukemia (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Terminal Colitis	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 14 days 11 Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 22, 1961 to Oct. 3, 1961, that (I) (we) last saw the deceased alive on Oct. 3, 1961, and that death occurred at 6:35 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Henderson, M.D.		22b. DATE SIGNED 10/3/61	
22c. PHYSICIAN'S NAME (Type) EDWARD S. HENDERSON, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/61	
23c. NAME OF CEMETERY OR CREMATORY —		23d. LOCATION (City, town or county) (State) Elizabeth City, N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		25a. REC'D BY REGISTRAR DATE OCT 4 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

11

2001

Technical Committee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11507

Items 8 & 9 Film G209 11/1/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

11492

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>	
c. LENGTH OF STAY IN 1b <u>10 yr 9m</u>		d. STREET ADDRESS <u>25-Cleveland Ave. 1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minerva Emily Baum</u>		4. DATE OF DEATH Month Day Year <u>Oct. 22 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1876 June 23, 1874/1887/1</u>
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Walter Graves</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Anne Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John C. Baum</u>		Address <u>4017 Cleveland St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal ca - Rt. breast</u> 170X DUE TO <u>Rem. metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 18, 1959</u> to <u>Oct 22, 1961</u> , that I last saw the deceased alive on <u>Oct 13, 1961</u> , and that death occurred at <u>9 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>OLNEY, MD</u> DATE SIGNED <u>10/22/61</u>	
PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>		<u>Olney, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 25 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>			

11201

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME (Last, first, middle initial)
JAMES BROWN

DATE OF BIRTH
1890

PLACE OF BIRTH
BALTIMORE, MARYLAND

DATE OF DEATH
1910

PLACE OF DEATH
BALTIMORE, MARYLAND

CAUSE OF DEATH
TUBERCULOSIS

SEX
MALE

AGE
20

EDUCATION
HIGH SCHOOL

OCCUPATION
CLERK

RELIGION
METHODIST

USUAL RESIDENCE
BALTIMORE, MARYLAND

DECEASED'S SIGNATURE
JAMES BROWN

TESTED BY
JAMES BROWN

DATE
1910

PLACE
BALTIMORE, MARYLAND

REGISTRATION NO.
12345

FILE NO.
12345

11201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11508

11493

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8101 Old Georgetown Road				d. STREET ADDRESS 8101 Old Georgetown Road					
3. NAME OF DECEASED (Type or print) STELLA N. BEAN				4. DATE OF DEATH Month October Day 29 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/11/1891			
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Walter Haney				14. MOTHER'S MAIDEN NAME Eva K. Morrison					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None					
17. INFORMANT Everett Bean-Husband-same 2d				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL PULMONARY EDEMA 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SURGERY - 2 MESENTERIC THROMBOSES - AUG 1961								INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 19 60 to OCT 27 19 61 , that (I) (we) last saw the deceased alive on OCT 27 19 61 , and that death occurred at 5A M, from the causes and on the date stated above.									
22a. SIGNATURE Leo I Donouan M.D.				22b. DATE SIGNED 10/30/61		22c. PHYSICIAN'S NAME (Type) LEO I DONOUAN M.D.			
22d. ADDRESS 8318 WISE AVE BETHESDA 14 MD				22e. REC'D BY REGISTRAR Nov 2 '61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/61		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				25. REGISTRAR'S SIGNATURE Arthur S. Kraus					



11303

Montgomery

Bethesda

8101 Old Georgetown Road

Maryland

Bethesda

8101 Old Georgetown Road

October 24

October 24

USA

Maryland

Mr. A. Morrison

Verde Court - Bethesda - Md 20814

Valley View

Phone



Rockville, Maryland

Rockville Cemetery

11/1/61

Funeral

Robert A. Humphrey, Bethesda, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11509

11494

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wash. D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland				c. LENGTH OF STAY IN 1b 5 years.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8702 Geren Road,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ora Middle Gerhart Last Beatty				4. DATE OF DEATH Month 10 Day 6 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8th, 1872	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist				10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Aaron Gerhart				14. MOTHER'S MAIDEN NAME Sarah Dally			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO. 578 20 980		17. INFORMANT Daughter		Address Iris Beatty Johnson 3829 S Street, N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive - Arteriosclerotic DUE TO (c) Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 72 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 61 to Oct 61 , that (I) (we) last saw the deceased alive on 10-3 19 61 , and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE Bernard A. Fitzgerald				22b. ADDRESS 217 Univ. Bldg E. S.S., Md.		22c. PHYSICIAN'S NAME (Type) Bernard A. Fitzgerald	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/7/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Gincherson				25a. REC'D BY REGISTRAR DATE OCT 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

WASH D.C.

11503

(M)

WATER SUPPLY, ...

WATER SUPPLY, ...

WATER SUPPLY, ...

WATER SUPPLY, ...

WATER SUPPLY, ...

WATER SUPPLY, ...

WATER SUPPLY, ...

WATER SUPPLY, ...

10-3-01

WATER SUPPLY, ...

WATER SUPPLY, ...

WATER SUPPLY, ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11510

11495

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WHEATON-MD c. LENGTH OF STAY IN 1b 10-14-61 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WHEATON NURSING-HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore (Halethorpe) d. STREET ADDRESS 1820 Woodside Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fanny First Middle Last		4. DATE OF DEATH October 16, 1961 Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1882 9. AGE (in years last birthday) 79 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Rufus Tyler		14. MOTHER'S MAIDEN NAME Annie LeBrun	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT James A. Bell Address (son) 1809 Arbutus Ave. #27			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 230X DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) Metastatic tumor of the liver - ascites		INTERVAL BETWEEN ONSET AND DEATH Hours Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cholelithiasis Arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (U) (this hospital) attended the deceased from 5-29-1961 to 10-16-1961 , that (U) (we) last saw the deceased alive on 10-16-1961 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles R Shultz, M.D.		22b. DATE SIGNED 10-16-61	
22c. PHYSICIAN'S NAME (Type) Charles R. Shultz, M.D.		22d. ADDRESS 9 Dewey Drive Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR OCT 18 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Howard H. Hubbard 4107 Wilkens Avenue

London Park Cemetery 10/19/61

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

073

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11511 CERTIFICATE OF DEATH 11496											
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG d. STREET ADDRESS EMORY GROVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WILLIAM			First Middle Last BELL			4. DATE OF DEATH OCT. 11 1961			Month Day Year		
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-77		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED (NOT KNOWN)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME WILLIAM DAYTON BELL						14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) UNKNOWN				16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO (b) Bilateral bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH 10 years 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from 10/8/61 to 10/11/61 , that (I) (we) last saw the deceased alive on 10/10/61 , and that death occurred at 3 P.M. from the causes and on the date stated above.											
22a. SIGNATURE James P. Kerr M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) JAMES P. KERR, M.D., DAMASCUS, MD.						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-14-61		23c. NAME OF CEMETERY OR CREMATORY Brooke Grove				23d. LOCATION (City, town or county) (State) Laytonsville, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. [Signature]				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]			



MONTGOMERY

MARYLAND

MONTGOMERY

OLNEY

3 DAYS

CATHERS

MONTGOMERY GENERAL

LIBBY CARVE

WILLIAM

BELL

OCT. 27

MALE

WARR

12-10-33

83

MARYLAND

RETIRED (NOT KNOWN)

UNKNOWN

WILLIAM DAYTON BELL

HOSPITAL RECORDS

UNKNOWN



William Dayton Bell
Retired (Not Known)
Maryland

WILLIAM DAYTON BELL

W. D. Bell

13
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

11512
11497
MONTGOMERY
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>23 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>402 Silver Rock Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maggie (Cappie) Benson</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/97</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
13. FATHER'S NAME <u>John Collins</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown) Felius</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-26-3740D</u>	
17. INFORMANT <u>Son Arthur Benson</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>coronary thrombosis</u> DUE TO <u>coronary arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis & asthma</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Same as above</u>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20d. (City or town) (County) (State) <u>Rockville</u> <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1951</u> to <u>10/4/1961</u> , that (I) (we) last saw the deceased alive on <u>10/4/1961</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen N. Jones</u>		22b. DATE SIGNED <u>10/4/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		22d. ADDRESS <u>809 Viers Mill Rd. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/7/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Potomac Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Potomac, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

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(M)

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Robert A. Murphy, Bethesda, Maryland

Burial

10/1/41

Episcopal Church, Washington, D.C.

10/1/41

200 West Hill St., Rockville, Md.

10/1/41

10/1/41

FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> <u>W.C.O.A.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Stn + Hosp</u>					d. STREET ADDRESS <u>1712 Hudson Ave</u>						
3. NAME OF DECEASED (Type or print) <u>Randy</u> <u>William Bestpitch</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>8-21-60</u> 9. AGE (In years last birthday) <u>1</u> yrs. <u>2</u> months <u>10</u> days <u>10</u> hours <u>10</u> min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>					10b. KIND OF BUSINESS OR INDUSTRY						
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>George Bestpitch</u>					14. MOTHER'S MAIDEN NAME <u>Elsie Cody</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>—</u>						
17. INFORMANT <u>George Bestpitch</u> Address <u>Same as above</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinosis of liver, congenital</u> DUE TO (b) <u>5810</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<u>10-31-61</u>	
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>Nov. 3, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>			
23. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>254 Carroll NW W. D.C.</u>					REC'D BY REGISTRAR <input checked="" type="checkbox"/> DATE <u>NOV 3 '61</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

STATE OF NEW YORK
DEPARTMENT OF HEALTH

(M)

1913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John J. Smith*

2. RESIDENCE: *123 Main St., New York City*

3. AGE: *45*

4. SEX: *Male*

5. OCCUPATION: *Teacher*

6. DATE OF DEATH: *Jan 15, 1913*

7. PLACE OF DEATH: *Home*

8. CAUSE OF DEATH: *Myocardial Infarction*

9. MANNER OF DEATH: *Natural*

10. SIGNATURE OF EXAMINER: *Dr. J. H. Jones*

11. SIGNATURE OF ATTENDING PHYSICIAN: *Dr. A. B. Brown*

12. SIGNATURE OF CORONER: *John D. White*

13. SIGNATURE OF JURY: *James E. Black*

14. SIGNATURE OF WITNESSES: *William C. Green*

15. SIGNATURE OF FUNERAL HOME: *Robert F. Hall*

16. SIGNATURE OF BURIAL PLACE: *St. Mary's Cemetery*

17. SIGNATURE OF VENDOR: *John K. Lee*

18. SIGNATURE OF OTHER: *John M. King*

19. SIGNATURE OF OTHER: *John N. King*

20. SIGNATURE OF OTHER: *John O. King*

21. SIGNATURE OF OTHER: *John P. King*

22. SIGNATURE OF OTHER: *John Q. King*

23. SIGNATURE OF OTHER: *John R. King*

24. SIGNATURE OF OTHER: *John S. King*

25. SIGNATURE OF OTHER: *John T. King*

26. SIGNATURE OF OTHER: *John U. King*

27. SIGNATURE OF OTHER: *John V. King*

28. SIGNATURE OF OTHER: *John W. King*

29. SIGNATURE OF OTHER: *John X. King*

30. SIGNATURE OF OTHER: *John Y. King*

31. SIGNATURE OF OTHER: *John Z. King*

32. SIGNATURE OF OTHER: *John A. King*

33. SIGNATURE OF OTHER: *John B. King*

34. SIGNATURE OF OTHER: *John C. King*

35. SIGNATURE OF OTHER: *John D. King*

36. SIGNATURE OF OTHER: *John E. King*

37. SIGNATURE OF OTHER: *John F. King*

38. SIGNATURE OF OTHER: *John G. King*

39. SIGNATURE OF OTHER: *John H. King*

40. SIGNATURE OF OTHER: *John I. King*

41. SIGNATURE OF OTHER: *John J. King*

42. SIGNATURE OF OTHER: *John K. King*

43. SIGNATURE OF OTHER: *John L. King*

44. SIGNATURE OF OTHER: *John M. King*

45. SIGNATURE OF OTHER: *John N. King*

46. SIGNATURE OF OTHER: *John O. King*

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48. SIGNATURE OF OTHER: *John Q. King*

49. SIGNATURE OF OTHER: *John R. King*

50. SIGNATURE OF OTHER: *John S. King*

51. SIGNATURE OF OTHER: *John T. King*

52. SIGNATURE OF OTHER: *John U. King*

53. SIGNATURE OF OTHER: *John V. King*

54. SIGNATURE OF OTHER: *John W. King*

55. SIGNATURE OF OTHER: *John X. King*

56. SIGNATURE OF OTHER: *John Y. King*

57. SIGNATURE OF OTHER: *John Z. King*

58. SIGNATURE OF OTHER: *John A. King*

59. SIGNATURE OF OTHER: *John B. King*

60. SIGNATURE OF OTHER: *John C. King*

61. SIGNATURE OF OTHER: *John D. King*

62. SIGNATURE OF OTHER: *John E. King*

63. SIGNATURE OF OTHER: *John F. King*

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68. SIGNATURE OF OTHER: *John K. King*

69. SIGNATURE OF OTHER: *John L. King*

70. SIGNATURE OF OTHER: *John M. King*

71. SIGNATURE OF OTHER: *John N. King*

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81. SIGNATURE OF OTHER: *John X. King*

82. SIGNATURE OF OTHER: *John Y. King*

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84. SIGNATURE OF OTHER: *John A. King*

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86. SIGNATURE OF OTHER: *John C. King*

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88. SIGNATURE OF OTHER: *John E. King*

89. SIGNATURE OF OTHER: *John F. King*

90. SIGNATURE OF OTHER: *John G. King*

91. SIGNATURE OF OTHER: *John H. King*

92. SIGNATURE OF OTHER: *John I. King*

93. SIGNATURE OF OTHER: *John J. King*

94. SIGNATURE OF OTHER: *John K. King*

95. SIGNATURE OF OTHER: *John L. King*

96. SIGNATURE OF OTHER: *John M. King*

97. SIGNATURE OF OTHER: *John N. King*

98. SIGNATURE OF OTHER: *John O. King*

99. SIGNATURE OF OTHER: *John P. King*

100. SIGNATURE OF OTHER: *John Q. King*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be evaluated within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11514											
11499											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5421 York Lane						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5421 York Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ida Belle BOGGS						4. DATE OF DEATH Oct. 8 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1872		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 8 Days 9 IF UNDER 24 HRS. Hours 8 Min. 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ----				11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sanders Puray						14. MOTHER'S MAIDEN NAME Mary Johnson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Marion W. Boggs-Son-Same 2d		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion - 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease - DUE TO (c) Pulmonary Emphysema - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of Colon - INTERVAL BETWEEN ONSET AND DEATH 10 min - 5 months - 10 yr -											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 , 19... to 8 Oct , 19 61 , that (I) (we) last saw the deceased alive on 29 Sept , 19 61 , and that death occurred at 3:00 PM , from the causes and on the date stated above.											
22a. SIGNATURE John G. Ball						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9 Oct 1961	
22c. PHYSICIAN'S NAME (Type) John G. Ball						22d. ADDRESS 7936 Old Georgetown Rd. Beth. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur, Trans		23b. DATE THEREOF 10/10/61		23c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery				23d. LOCATION (City, town or county) (State) Columbia, Missouri			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland						25a. REC'D BY REGISTRAR OCT 13 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus			

11214

Montgomery

Bedford

1021 York Lane

Ida

Female White

Monmouth

Sandra Perry

No

None

Marion - 6042-20-2000 M

Harry Johnson

Missouri

Jan. 20, 1930

BOGG

Belie

1021 York Lane

Bedford

Montgomery



John G. Ball

10/10/41 Memorial Cemetery

Robert A. Humphrey, Bedford, Maryland

Columbia, Missouri

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Bethesda					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8614 Lancaster Drive						d. STREET ADDRESS 8614 Lancaster Drive					
3. NAME OF DECEASED (Type or print) MARGARET L. BRAGAW						4. DATE OF DEATH Month Oct. Day 15 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27, 1888		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 3 Days 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William J. Butler						14. MOTHER'S MAIDEN NAME Louise Ellen Andrews					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT George D. Bragaw-Son-same 2d					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) arteriosclerotic heart disease (c) myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 25 years immed.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from May 17, 1961 to Oct 11, 1961 , that (1) (we) last saw the deceased alive on Oct 11, 1961 and that death occurred at 10 AM , from the causes and on the date stated above.											
22a. SIGNATURE Wilfred R. Ehrmantraut M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut						22d. ADDRESS 4890 Battery Lane, Bethesda, Md.		22b. DATE SIGNED 10/16/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/18/61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Prince George Co. Maryland		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland						25a. REC'D BY REGISTRAR DATE OCT 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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M

Montgomery

Maryland

Montgomery

Bethesda

Bethesda

841- Lancaster Drive

841- Lancaster Drive

Oct. 13

Oct. 13

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Oct. 13

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Jan. 27, 1986 73 - 13

Jan. 27, 1986 73 - 13

Washington, D.C.

Washington, D.C.

Postage: Allen Andrews

William D. Smith

George D. Brownson-Rams 24

None

Unrecorded information

Oct 11 1986

11/11/86

Postage: Allen Andrews

Unrecorded information

Robert A. Tushnet, Bethesda, Maryland
Partial 10/10/86
Lt. Lincoln Cemetery Prince George Co. Maryland

1
X
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

X

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
11516					11501					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Montgomery					a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase					b. COUNTY Montgomery					
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 Chevy Chase					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4700 Bradley Blvd.					d. STREET ADDRESS 4700 Bradley Blvd.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last Dudley S. Bright					Month Day Year October 5, 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/19/84		9. AGE (In years last birthday) 77 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer-Ret. Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.		
13. FATHER'S NAME Albert W. Bright		14. MOTHER'S MAIDEN NAME Mollie Hutchinson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes WW II		16. SOCIAL SECURITY NO. 084-07-7358		17. INFORMANT Albert Bright, son		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Address 4809 Broadbrook Dr. Beth, Md.						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of gastric contents		INTERVAL BETWEEN ONSET AND DEATH Sudden								
177X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		DUE TO (b) Sarcinomatosis								
		DUE TO (c) Primary leiomyosarcoma, prostate		1 year						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Atherosclerotic heart disease										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1959 to Oct 4 , 19 61 , that (I) (we) last saw the deceased alive on Oct 4 , 19 61 , and that death occurred at 12 M., from the causes and on the date stated above.										
22a. SIGNATURE George Sharpe					M.D. Oct. 6, 1961		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) GEORGE SHARPE					22d. ADDRESS 10511 Sumit Ave., Kensington, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-9-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia		23d. LOCATION (City, town or county) (State)				
24 FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY					ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR OCT 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

100

2121

0225-70-430

10-9-61 10-9-61

CERTIFICATE OF DEATH

11517

11502

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb D.O.A		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. DATE OF DEATH Month 10 Day 25 Year 1961		g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		h. STREET ADDRESS 9309-19th Ave #201	
3. NAME OF DECEASED (Type or print) Robert		First Robert Middle Louis Last Bromley		4. DATE OF DEATH Month 10 Day 25 Year 1961		5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19-1895		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 6 Days 6		11. IF UNDER 24 HRS. Hours 6 Min. 6	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker		12b. KIND OF BUSINESS OR INDUSTRY Banking		13. BIRTHPLACE (County & State, or foreign country) Washington D.C.		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME William R. Bromley	
16. MOTHER'S MAIDEN NAME Julia Johnson		17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W.I		18. SOCIAL SECURITY NO. 578-05-2420		19. INFORMANT Jennie R. Bromley - wife		20. ADDRESS 2110 Maryland Ave N.E. Washington D.C.	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 42.0.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Atherosclerosis DUE TO (c) Several Years		22. INTERVAL BETWEEN ONSET AND DEATH 10 min		23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		25. MEDICAL CERTIFICATION 26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 26b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 26c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 26d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 26e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 26f. (City or town) (County) (State)	
27. I certify that (I) (this hospital) attended the deceased from October 19, 1960 to October 25, 1961 , that (I) (we) last saw the deceased alive on October 23, 1961 , and that death occurred at 7:25 A.M. from the causes and on the date stated above.		28. SIGNATURE Bennet A. Porter, Jr.		29. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 29a. ADDRESS 9301 Colesville Rd Silver Spring Md		30. DATE SIGNED October 25, 1961		31. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr. MD	
32. BURIAL, CREMATION, REMOVAL (Specify) Burial		33. DATE THEREOF 10/28/61		34. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		35. LOCATION (City, town or county) (State) Prince George's County, Md.		36. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska Warner E. Pumphrey, Inc.	
37. ADDRESS 8434 Georgia Avenue Silver Spring, Md.		38. REC'D BY REGISTRAR OCT 27 '61		39. REGISTRAR'S SIGNATURE Arthur L. Kline		40. DATE		41. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

VR A15 (4)
15M 9/60

(M)

(1)

(A)

(B)

Robert A. Imbrie, Inc. Silver Spring, Md.

and Robert A. Imbrie

Robert A. Imbrie

Prince George's County, Md.

Oct 1, 1961

1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
11518					11503							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY in 1b 47hrs 18min		a. STATE MARYLAND		b. COUNTY HOWARD (MOTHER)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY (JONESTOWN)					d. STREET ADDRESS 13 X - 2		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. MONTH			6. DAY		
First Middle Last Baby Boy "B" BROOKS					10- 3		10- 3			19 61		
5. SEX male		6. COLOR OR RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-1-61 6:47PM		9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months Days 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) newborn		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William Chambers					14. MOTHER'S MAIDEN NAME Mary Dell Brookes							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO. Hospital Records					17. INFORMANT Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH 2 DAYS		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL												
763.5 } DUE TO (b) ATELECTASIS, CONGENITAL												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) -												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
PREMATURITY												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from 10-1-61 , 19 61 , to 10-3-61 , 19 61 , that (I) (we) last saw the deceased alive on 10-3 , 19 61 , and that death occurred at 6:15PM , from the causes and on the date stated above.												
22a. SIGNATURE Charles S. Whitaker, B.D.					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-4-61	
22c. PHYSICIAN'S NAME (Type) Dr. Charles Whitaker, M.D.					22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-8-61		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park		23d. LOCATION (City, town or county) Rockville, Md.		(State)				
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden					ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE OCT 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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11518

(M)

(I)

(HONORABLE J. EDGAR HOOVER)

WASHINGTON

(CITY OF BOSTON)

THOMAS L. BROWN

CONFIDENTIAL (ORIGINAL FILED)

THOMAS L. BROWN

10-1-61

10-1-61

CONFIDENTIAL (ORIGINAL FILED)

THOMAS L. BROWN

CONFIDENTIAL (ORIGINAL FILED)

CONFIDENTIAL (ORIGINAL FILED)

CONFIDENTIAL (ORIGINAL FILED)

CONFIDENTIAL (ORIGINAL FILED)

CONFIDENTIAL

10-1-61

10-1-61

6:12PM

of

10-1

10-1-61

CONFIDENTIAL (ORIGINAL FILED)

CONFIDENTIAL (ORIGINAL FILED)

10-1-61

CONFIDENTIAL (ORIGINAL FILED)

1/2
The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11519

Item 8 Film G297 10/18/61 ink

11504

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Saniterium + Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 11 Montgomery Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Thomas Brown		4. DATE OF DEATH 10 - 12 - 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 11 - 18 - 8/6/76
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt - Walter Reed Hosp	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Brown		14. MOTHER'S MAIDEN NAME Mary Elizabeth Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Hosp. Records	
17. INFORMANT Hosp. Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) 331X (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1955 to Oct 12 1961 , that (I) (we) last saw the deceased alive on Oct 12 1961 , and that death occurred at 3:18 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James M. Whitlock M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10-12-61
22c. PHYSICIAN'S NAME (Type) James M. Whitlock M.D.		22d. ADDRESS 7717 Carroll Ave Takoma Park Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 16, 1961	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City, town or county) (State) Washington, D.C.
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters - 254 Carroll St. N.W. Wash, D.C.		25a. REC'D BY REGISTRAR DATE OCT 16 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11505

11520

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Dist. of Columbia b. COUNTY Columbia ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 2901 Connecticut Ave. N.W.	
3. NAME OF DECEASED (Type or print) First Frank Middle I Last BROWN		4. DATE OF DEATH Month 10 Day 22 Year 1961	
5. SEX Male	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-86
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Attorney for Federal Trade Commission		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Irving A. Brown		14. MOTHER'S MAIDEN NAME Mary Cunningham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Address Mrs. Ella A. Brown - 2901 Conn. Ave., N.W. Washington, D.C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 5 days (c) 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/2 19 50 to 10/22 19 61 , that (I) (was) lost saw the deceased alive on 10/22 19 61 and that death occurred on 6:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John E. Everett M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT		22d. ADDRESS 9400 CONN. AVE. Kensington Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/61	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John B. H. Smith Co.		25a. REC'D BY REGISTRAR 2901-1498 N.W.	
25b. REGISTRAR'S SIGNATURE		DATE OCT 24 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11508

11560

(7)



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11521

11506

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE D.C. b. COUNTY -- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5105 North Capitol Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Herman Middle W. Last Brown				4. DATE OF DEATH Month October Day 13 Year 19 61					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1919		9. AGE (In years last birthday) 42 yrs. IF UNDER 1 YEAR: Months 4 Days 28 IF UNDER 24 HRS.: Hours 2 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed-- Construction Work				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilfred W. Brown				14. MOTHER'S MAIDEN NAME Iva I. Rogers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Address Laura S. Brown-- Same #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive Heart Failure DUE TO (b) old coronary occlusion Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 6 mo. 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus - Pyelo nephritis								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) does not apply					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the doctor) attended the deceased from August 1950 to Oct. 13, 1961 , that (I) last saw the deceased alive on Oct. 12, 1961 , and that death occurred Oct. 13, 1961 from the causes and on the date stated above.									
22a. SIGNATURE Paul Eanet				22b. DATE SIGNED 10-13-61		22c. PHYSICIAN'S NAME (Type) Paul Eanet		22d. ADDRESS 6727 - 16th St. N.W. D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges Co. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company				25a. REC'D BY REGISTRAR OCT 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11522

CERTIFICATE OF DEATH

11507

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 81 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 5 Stanley Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Elizabeth Bryant		4. DATE OF DEATH Month October Day 10 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 29, 1917
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min. 4	11. IF UNDER 24 HRS. Hours 4 Min. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Walsh		14. MOTHER'S MAIDEN NAME Anne Manley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO (b) Myelophthisic anemia DUE TO (c) Metastatic carcinoma of breast	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 170X		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 21, 1961 to October 10, 1961 , that (I) (we) last saw the deceased alive on October 10, 1961 , and that death occurred at 1:45 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Marvin A. Kirschner M.D.		22b. DATE SIGNED Oct 10, 1961	
22c. PHYSICIAN'S NAME (Type) MARVIN A KIRSCHNER, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-14-61	
23c. NAME OF CEMETERY OR CREMATORY St. Marys		23d. LOCATION (City, town or county) (State) Scranton Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 3072-M St. M. W.		25a. REC'D BY REGISTRAR OCT 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kirschner			



11523

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11508

1. PLACE OF DEATH a. COUNTY Mont.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD.		b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, MD	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hosp		d. STREET ADDRESS 509 Denham Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joyce T. Bucarich		First Middle Last		4. DATE OF DEATH Oct 7 1961	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 30, 1933		9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY #11 West Virginia		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME OSCAR MINOR MAHONE		14. MOTHER'S MAIDEN NAME NANA STATON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mr. Wm. C. Bucarich # 2d.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage + laceration 976X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Self-inflicted bullet wound - rt temple DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted bullet wound			
20c. TIME OF INJURY Month, Day, Year 6:45 p.m. 10-7-1961		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> el work <input type="checkbox"/> Not While <input type="checkbox"/> el work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Rockville		20g. (County) Montgomery		20h. (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-7-61	
ACTUAL SIGNATURE Frank J. Brosch		M.D. FRANK J. Brosch		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Brosch		Address (Street, city, town, or county) 317 PA. AVE. SE.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/61		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	
22d. LOCATION (City, town, or country) ARLINGTON, VA.		22e. REC'D BY REGISTRAR OCT 11 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Hume	

VS. A15ME
5M 7/59

631

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11509

11524

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eventide Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
3. NAME OF DECEASED (Type or print) First Middle Last Josephine Buechler		4. DATE OF DEATH Month Day Year October 20, 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 87 yrs.	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Thomas W. Ryan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Bennetta Onion	
16. SOCIAL SECURITY NO. ?		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) Arteriosclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 2 months 1 year 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) Severe hypertrophic arthritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 28 June, 1961 , to 20 Oct , 1961, that I last saw the deceased alive on 18 Oct , 1961, and that death occurred at 9:45 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 927 Pershing Drive, Silver Spring 10-20-61			
ACTUAL SIGNATURE Seruch T. Kimble		M.D. 927 Pershing Drive, Silver Spring 10-20-61	
PHYSICIAN'S NAME (Type) Seruch T. Kimble		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10/23/61	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR Oct 23 61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		24c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11525

Item 9 Film G298 10/25/61 iwk

11510

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bethesda		c. LENGTH OF STAY IN 1b 33 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNH, MNMC, Bethesda, Md.		d. STREET ADDRESS 4312 Glenrose St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Aloysius Patrick BURNS		4. DATE OF DEATH Oct 15 1961		Month Day Year	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Mar 96	9. AGE (In years last birthday) 65 6/2 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Aloysius BURNS		14. MOTHER'S MAIDEN NAME Margaret HALLEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 216-40-6588		17. INFORMANT Edna Magdlane BURNS 4312 Glenrose St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 11 Sept 1961 to 15 Oct 1961	(County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11 Sept 1961 to 15 Oct 1961 that (I) last saw the deceased alive on 15 Oct 1961 , and that death occurred at 2:10 AM from the causes and on the date stated above.					
22a. SIGNATURE W F Warrander		M.D. W F WARRANDER		22b. DATE SIGNED Oct 17 '61	
22c. PHYSICIAN'S NAME (Type) W F WARRANDER		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington		(State) Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Hanlon Timothy		ADDRESS Funeral Home Washington, D.C.		25a. REC'D BY REGISTRAR OCT 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

1155

(M)

Washington, D.C. 20540

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Re: [Illegible]

Date: [Illegible]

Washington, D.C.

Very truly yours,

[Illegible Signature]

Enclosure

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11526

CERTIFICATE OF DEATH

Item 23b, Film G297 10/20/61 ink

11511

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 10 Williams Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 11 days		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital	
3. NAME OF DECEASED (Type or print) Arthur Valentine Bush		4. DATE OF DEATH Month Day Year October 13 1961	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 11, 1999 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RT TEMPORAL LOBE INFARCT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CEREBRAL THROMBOSIS (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from October 3, 1961 to October 13, 1961 , that (X) (we) last saw the deceased alive on October 13, 1961 , and that death occurred at 8:15 PM from the causes and on the date stated above.			
22a. SIGNATURE R.W. Mackie M.D.		22b. DATE 14 October 1961	
22c. PHYSICIAN'S NAME (Type) R.W. MACKIE, CAPTAIN, (MC) USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/61	
23c. NAME OF CEMETERY OR CREMATORY Pond Hill Cemetery		23d. LOCATION (City, town or county) (State) Pond Hill, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE R. J. PUMPHREY Funeral Home, Bethesda, Maryland		25a. REC'D BY REGISTRAR OCT 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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W. W. Walker

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 2 Form G299 11/2/61 iwk											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George's</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u>					
c. LENGTH OF STAY in lb <u>Do A.</u>						d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A. I. Fargnoli</u>					
3. NAME OF DECEASED (Type or print) <u>Arthur</u> First <u>Waldo</u> Middle <u>Byam</u> Last						4. DATE OF DEATH <u>Oct</u> 22 19 <u>61</u> Day Year					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-29-1884</u>		9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Mary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		13. FATHER'S NAME <u>Arthur T. Byam</u>		14. MOTHER'S MAIDEN NAME <u>Susie Cornelius</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Nursing Home Record</u>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Exposure - Body badly decomposed.</u> 795-4 DUE TO (b) <u>Had wound away from nursing home Oct 8 1961. Body found in field about 1/2 mi from home</u> DUE TO (c) <u>Was also a mental case</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-22-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)		23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
<u>Burial</u>		<u>10-24-61</u>		<u>Village Cemetery</u>		<u>Fitzwilliam, New Hampshire</u>		<u>Francis H. Barber</u>		<u>OCT 26 '61</u>	
ADDRESS <u>Laytonville, Md.</u>						24b. REGISTRAR'S SIGNATURE <u>Caring S. K...</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 6 minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ft. Meade d. STREET ADDRESS 7223G Hall Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Michael Allen Byars		4. DATE OF DEATH Month October Day 19 Year 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 19, 1961	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE (In years last birthday) yrs. 0 Months 0 Days 0 Hours 6 Mins. 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tony (n) Byars		14. MOTHER'S MAIDEN NAME Virginia Clair Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. FA: Tony Byars, same as #2	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY DUE TO INCOMPETENT CERVIX Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) INCOMPETENT CERVIX (c) INCOMPETENT CERVIX PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from October 19, 1961 , to October 19, 1961 , that (I) (we) last saw the deceased alive on October 19, 1961 , and that death occurred at 2:33 AM from the causes and on the date stated above.			
22a. SIGNATURE C. R. Boyce M.D.		22b. DATE SIGNED October 19, 1961	
22c. PHYSICIAN'S NAME (Type) C. R. BOYCE LCDR MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 20, 1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS 7557 Wisconsin Ave., Bethesda Md.		25a. REC'D BY REGISTRAR OCT 23 '61	
25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey		25c. REGISTRAR'S SIGNATURE Robert A. Pumphrey	

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11528

CERTIFICATE OF DEATH

11519



Handwritten signature
James M. Smith

Handwritten signature
W. L. Smith



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Birth Wt. 1 lb 2 oz 152g

11514

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 2 hrs. 11 min d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 09 ROCKVILLE d. STREET ADDRESS 1243 EAST MONTGOMERY AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BABY First Boy Middle Calloway Last Calloway			4. DATE OF DEATH OCTOBER 16 19 61 Month OCTOBER Day 16 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> NB DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH OCTOBER 16, 1961		9. AGE (In years last birthday) — yrs. — Months — Days — Hours 2 Min. 11		IF UNDER 1 YEAR — Months — Days — Hours — Min. —		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —			10b. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY County, MD			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MELVIN "B" CALLOWAY			14. MOTHER'S MAIDEN NAME VERA ELIZABETH HEATH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes give year or dates of service) —			16. SOCIAL SECURITY NO. —			
17. INFORMANT —			Address —			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —						INTERVAL BETWEEN ONSET AND DEATH —
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour — e.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		
20f. (City or town) —		20g. (County) —		20h. (State) —		
21. I certify that (I) (this hospital) attended the deceased from 10/16 to 10/16 , 19 61 , that (I) (we) last saw the deceased alive on 10/16 , 19 61 , and that death occurred at 11 PM , from the causes and on the date stated above.						
22a. SIGNATURE Emilie C. Black M.D.			22b. DATE SIGNED 10/16			
22c. PHYSICIAN'S NAME (Type) EMILIE C. BLACK, MD			22d. ADDRESS 5000 ALTA VISTA RD, Bethesda MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 10/18/61		23c. NAME OF CEMETERY OR CREMATORY SUBURBAN HOSPITAL		
23d. LOCATION (City, town or county) BETHESDA, MARYLAND		23e. (State) —		23f. (Country) —		
24. FUNERAL DIRECTOR'S SIGNATURE AMELIA C. CARTER, ADMIN. - (for F.B.)			25a. REC'D BY REGISTRAR —			
25b. REGISTRAR'S SIGNATURE —			25c. DATE OCT 20 '61			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11530

11515

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John d. STREET ADDRESS 6515 78th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Herbert Lee Carter		4. DATE OF DEATH Month October Day 26 Year 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 26, 1911		9. AGE (In years last birthday) 50 yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water Plant Operator				10b. KIND OF BUSINESS OR INDUSTRY Water plant				11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Henry Carter						14. MOTHER'S MAIDEN NAME Birdie V. Loy															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. 578-32-4351				17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 10 minutes 7 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that XX (this hospital) attended the deceased from October 21, 1959 to October 26, 1961 , that XX (we) last saw the deceased alive on October 24, 1961 , and that death occurred at 5:30 PM , from the causes and on the date stated above.																					
22a. SIGNATURE W. A. Pettinger, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED October 27, 1961											
22c. PHYSICIAN'S NAME (Type) William A. Pettinger						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/29/61		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery				23d. LOCATION (City, town or county) (State) Burtonsville, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland						25a. REC'D BY REGISTRAR OCT 30 '61		25b. REGISTRAR'S SIGNATURE <i>Charles E. Kraus</i>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Not a medical examiner's case



THE UNIVERSITY OF CHICAGO

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11531

11516

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>To Komo Park</u>		c. LENGTH OF STAY IN 1b <u>5 mo. 1 day 1 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. and Hospital</u>				d. STREET ADDRESS <u>2631 Naylor Rd. S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Alma Mae Casebeer</u>				4. DATE OF DEATH Month Day Year <u>Oct. 23 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 25, 1884</u>		9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard W. Frye</u>				14. MOTHER'S MAIDEN NAME <u>Helen Mossburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>..</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adhesions</u> DUE TO (c) <u>Carcinoma of the Sigmoid</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>? months</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Bilat Sciatica</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/10/1955</u> 19 <u>55</u> , to <u>10/23/1961</u> , that (I) (we) last saw the deceased alive on <u>10/23/1961</u> , and that death occurred at <u>2:19</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert A. Hare</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD</u>				22d. ADDRESS <u>7600 Carroll Ave. Tak. PR, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 25-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Lutland Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>				25a. REC'D BY REGISTRAR <u>1661 Good Hope Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Montgomery

James Park

Washington Park (Hospital)

Mrs. A. A.

George A. A.

John A. A.

Thomas A.

Thomas A.

Richard W. A.

Richard W. A.

Richard W. A.

Richard W. A. (continued)

1082

CERTIFICATE OF DEATH

State of New York
County of Albany
City of Albany
I, the undersigned, being a duly qualified physician, do hereby certify that
on the 10th day of May, 1910, at the City of Albany, New York,
I attended the deceased, who was known to me as
Mary J. Smith, and who was born on the 10th day of May, 1840,
at the City of Albany, New York, and who died of
old age, at the residence of the deceased, at the City of Albany,
New York, and who was buried in the City of Albany, New York,
on the 12th day of May, 1910, at the City of Albany, New York,
in the presence of the undersigned, and of the following persons:
John J. Smith, Henry J. Smith, and Mary J. Smith.
Witness my hand and the seal of my office, this 10th day of May, 1910.
Robert A. Thompson, M.D., City of Albany, New York.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11533

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11518

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5516 Wilson Lane</u>				d. STREET ADDRESS <u>2475 Va. Ave. NW</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SARA</u> Middle <u>H</u> Last <u>CHAPPELEAR</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 21, 1884</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Higgenbotham</u>				14. MOTHER'S MAIDEN NAME <u>Sara (Sally) Cochran</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>5516 Wilson Lane</u> <u>DAUGHTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatous - original site undetermined</u> 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Atherosclerosis generalized</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>Oct 18</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Oct 17</u> 19 <u>61</u> , and that death occurred at <u>6 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles W. Opdman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 18, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES W. OPDMAN</u>				22d. ADDRESS <u>1726 M St. NW - WASH DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>		25b. REGISTRAR'S SIGNATURE <u>DATE OCT 20 '61</u>	

11512

CENTRAL AIR OF MEXICO

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CHEMICAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11534					11519						
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN lb <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>2502 Henderson Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Robert Hill Childers</u>					4. DATE OF DEATH <u>October 11 1961</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 23, 1894</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service man</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Richard Apperson Childers</u>					14. MOTHER'S MAIDEN NAME <u>Jane Combs</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>					16. SOCIAL SECURITY NO. <u>WIPE: Mrs. Pauline L. Childers, Same as #2</u>					17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 suffocation</u> DUE TO (b) <u>aspiration of vomitus</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 minute</u> INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U. S. Naval Hosp. Bethesda, Md.</u>		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 5, 1961</u> to <u>October 11, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 11, 1961</u> , and that death occurred at <u>2:49 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Paul G. Linaweaver</u>					22b. DATE SIGNED <u>11 October 1961</u>			22c. PHYSICIAN'S NAME (Type) <u>PAUL G. LINAWEAVER, LCDR MC USN</u>			
22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>16 Oct 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan</u> ADDRESS <u>Funeral Home, Washington, D. C.</u>					25a. REC'D BY REGISTRAR <u>OCT 16 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>				

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RECEIVED, 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
11535 CERTIFICATE OF DEATH 11520													
1. PLACE OF DEATH e. COUNTY <i>Montgomery MARYLAND</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>md.</i> b. COUNTY <i>Mont. Co.</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>						d. STREET ADDRESS <i>1409 Baltimore Rd.</i>							
3. NAME OF DECEASED (Type or print) <i>Charles Patrick Clark</i>						4. DATE OF DEATH <i>Oct. 5 1961</i>							
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/19/194</i>		9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Automobile Maryland</i>		11. BIRTHPLACE (County & State, or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY		IF UNDER 24 HRS. Hours Min.					
13. FATHER'S NAME <i>Charles Mason Clark</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Lamb</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, unknown) (If yes give year or dates of service) <i>Not Guard</i>					
16. SOCIAL SECURITY NO. <i>220-07-3191</i>				17. INFORMANT <i>Geneva Clark</i>				Address <i>same as above</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 58110 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>anemia from bleeding esophageal varices</i> (c) <i>Lance cirrhosis</i> cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>congestive heart failure</i>												INTERVAL BETWEEN ONSET AND DEATH <i>22 hours</i> <i>15 years</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>													
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>													
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)													
20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <i>March 1957</i> to <i>Oct 5 1961</i> , that (I) we last saw the deceased alive on <i>Oct 5</i> 19 <i>61</i> , and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>Stephen C. Cromwell</i> M.D.													
22b. DATE SIGNED <i>10-6-61</i>													
22c. PHYSICIAN'S NAME (Type) <i>STEPHEN C. CROMWELL</i>													
22d. ADDRESS <i>615 W. Montgomery Ave., Rockville, Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>													
23b. DATE THEREOF <i>10-9-61</i>													
23c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak Cemetery</i>													
23d. LOCATION (City, town or county) (State) <i>Montgomery Co., Maryland</i>													
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>ROBERT A. PUMPHREY Bethesda, Md.</i>													
25a. REC'D BY REGISTRAR <i>DET 13 '61</i>													
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>													

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[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]

STEPHEN O. CROWELL
615 W. Montgomery Ave., Rockville, Md.
Burial - 10-9-61
ROBERT A. FURTHNEY
Beltsville, Md.
Forest Oak Cemetery
Montgomery Co., Maryland

1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11521

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Belea mill Rd</u>				d. STREET ADDRESS <u>288 Dill Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Herbert A Clark</u>				4. DATE OF DEATH <u>Oct 28 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4 - 1905</u>	
9. AGE (in years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Herbert F Clark</u>				14. MOTHER'S MAIDEN NAME <u>Flora Arnold</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Ruth Clark (wife)</u>				Address <u>Stun 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bloesch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Bloesch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>10-28-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/30/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>OCT 31 '61</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haus</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1st attended - July 61 - Dr. Lily Blackstone, my address.
* Surgery - Aug. 16 - Dr. Thos. Wright - CA pancreas, retroperitoneal & liver
seen 10/10/61 Dr. Rockstad. & 10/13/61 Dr. Brown. Dr. Brown, my associates.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11537						11522					
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Silver Spring d. STREET ADDRESS 1124 Noelcrest Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Thomas Walter Clark First Middle Last						4. DATE OF DEATH 10 17 61 Month Day Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/28/07		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Internal Revenue				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME L. Frank Clark						14. MOTHER'S MAIDEN NAME Agnes Belle Venable					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) World War II				16. SOCIAL SECURITY NO.		17. INFORMANT Gladys M. Clark Address 1124 Noelcrest Dr. Sil Sp					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Pancreatic Carcinoma 157X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 157X DUE TO (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 0								INTERVAL BETWEEN ONSET AND DEATH 3 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1961 to 10/17/1961 , that we last saw the deceased alive on 10/13/1961 , and that death occurred at 740A M, from the causes and on the date stated above.											
22a. SIGNATURE Earle B. Thompson						22b. DATE SIGNED 10/17/61		22c. PHYSICIAN'S NAME (Type) EARLE B. THOMPSON MD			
22d. ADDRESS 1025 Vermont Ave NW, Wash, D.C.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town or county) Arlington, Virginia (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home ADDRESS 4812 Ga. Ave., N.W. Wash., DC						25a. REC'D BY REGISTRAR Oct 20 '61		25b. REGISTRAR'S SIGNATURE Carlton S. Hume			

1990

11533

CERTIFICATE OF DEATH

Reg. Dist. No.

11523

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 day 9 hrs. Redland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS Route #1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Margaret (NMI) Cline				4. DATE OF DEATH October 23, 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 29 1922 Jan 23, 1922	
9. AGE (In years last birthday) 44 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY Plantation Bn. Maryland			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Johnson				14. MOTHER'S MAIDEN NAME Ethel Carolisle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-24-9565			
17. INFORMANT Shirley Laurette (daughter)				Address Same as Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445x Berber Vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Delayed Reperfusion (c) 30 hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 15 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 15, 1961 , to Oct 23, 1961 , that I last saw the deceased alive on Oct 22, 1961 , and that death occurred at 12:50 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1250 M DATE SIGNED 10/23/61 ACTUAL SIGNATURE John S. Rogers M.D. John S. Rogers PHYSICIAN'S NAME (Type) John S. Rogers 1919 Seminary Road, Silver Spring, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/26/61			
22c. NAME OF CEMETERY OR CREMATORY Parklawn				22d. LOCATION (City, town, or county) (State) Rockville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland				24a. REC'D BY REGISTRAR DATE OCT 25 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1155

STATE OF TEXAS

1155

(M)

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into sections, possibly a list or a series of entries.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11524

11539

1. PLACE OF DEATH o. COUNTY MONTGOMERY , MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OWN HOME		d. STREET ADDRESS 3500 DECATUR AVE.	
3. NAME OF DECEASED (Type or print) First ADA Middle WRIGHT Last COCHRAN		4. DATE OF DEATH Month OCT. Day 22 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 9, 1872
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 8 Days 13 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BUTLER, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Wright		14. MOTHER'S MAIDEN NAME Hannah Maxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Helen C. Mason		Address 3500 DECATUR AVE. KENSINGTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis; hypertension DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 20 yrs.?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 8, 1959 , to Oct. 22, 1961 , that I last saw the deceased alive on Oct. 20, 1961 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip H. Varner		DATE SIGNED 10620 Ga. Ave., Wheaton, Md. 10-22-61	
PHYSICIAN'S NAME (Type) PHILIP H. VARNER		ADDRESS 10620 GA. AVE, WHEATON, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF OCT. 25, 1961	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE GREEN FUNERAL HOME		ADDRESS HERNDON, VA.	
24a. REC'D BY REGISTRAR DATE OCT 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0022-0067/97/0000-0000\$05.00/0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11540

Item 2 Film 9298 10/30/61 JWK

11525

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, MD c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CONGRESSIONAL MANOR NURSING HOME e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON DC c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) The Woodner - Washington, D.C. d. STREET ADDRESS 3636 -16th. St/ M/W. BETHESDA, MD.	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle COLLIMER Last COLLIMER 4. DATE OF DEATH Month OCTOBER Day 23 Year 1961		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH FEB 6, 1868 9. AGE (In years lost birthday) 93 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 11. BIRTHPLACE (State or foreign country) WASH. D.C. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (unknown) Jochum 14. MOTHER'S MAIDEN NAME unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. — 17. INFORMANT PATIENT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO 3 HOURS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) ARTERIOSCLEROSIS CORONARY ARTERIES DUE TO UNDET. (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from APRIL 1960 to OCT. 23, 1961 , that (I) (we) last saw the deceased alive on 10/23, 1961 , and that death occurred at 10:40 PM , from the causes and on the date stated above.	
22a. SIGNATURE Lawrence A. Rapee 22c. PHYSICIAN'S NAME (Type) LAWRENCE A. RAPEE, MD 22b. DATE SIGNED 10/23/1961 22d. ADDRESS 1150 CONN AVE NW WASH., D.C.		23a. BURIAL, CREMATION, REMOVAL Cremation 23b. DATE THEREOF 10-24-61 23c. NAME OF CEMETERY OR CREMATORY Lee's crematorium 23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE J. M. Lee & Sons ADDRESS 300 H St N.E. Washington 2, D.C. 25a. REC'D BY REGISTRAR DATE OCT 26 '61 25b. REGISTRAR'S SIGNATURE C. L. S. H. H. H.			

1952

1150

(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
ma retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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11541
11528
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>4 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Saniterium</i>		d. STREET ADDRESS <i>4607 69th Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle <i>K</i> Last <i>COOLEY</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>11</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3 June 1870</i>
9. AGE (In years lost birthday) <i>91</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Mass.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Johathan Ryden</i>		14. MOTHER'S MAIDEN NAME <i>Jane T. Eldridge</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Clifton Cooley Hyattsville Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO <i>Serious Hemorrhage; Ruptured Aorta</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis - senile</i> DUE TO <i>—</i> (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5/19/61</i> to <i>10/11/61</i> , that (I) (we) last saw the deceased alive on <i>10/11/61</i> 19 <i>1961</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>SAM Allen</i>		22b. DATE SIGNED <i>10/11/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>SAM Allen</i>		22d. ADDRESS <i>Kensington Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>10-15-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cranston</i>		23d. LOCATION (City, town, or county) (State) <i>Rhode Island</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. G. ...</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 16 61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>			

11221

(M)



(A)



11343

(M)

Montgomery

Maryland

Montgomery

3645 10-10-1934

Clincy

13 Brooks Avenue

Montgomery General Hospital

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Crawford

Cecil

Jessie

77

10-2-34

X

W

2

W.S.A.

Maryland

unknown

Julia May Thompson

Everett H. Cecil

Montgomery Records

no

Dr. J. L. Neal, M.D.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11543 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11528

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>R.F.D. #3 Box 65A</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Cromwell Jr.</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March, 4, 1917</u>	
9. AGE (in years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>For a private</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Edward Cromwell Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Anna Louise Palmer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NUMBER <u>Unknown</u>			
17. CAUSE OF DEATH (Enter only one cause per line for top, middle, and bottom) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericardial Tamponade</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laceration ant. descending coronary artery</u> DUE TO (c) <u>Crushed chest</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car which struck tree</u>			
20c. TIME OF INJURY Month, Day, Year <u>5:30 p.m. 10-18 1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Rockville Monty Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-15-61</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-18-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopehill</u>		22d. LOCATION (City, town, or country) (State) <u>Frederick, Co Md</u>	
23. FUNERAL DIRECTOR <u>C.E. Hicks, 111</u>				ADDRESS <u>Frederick, Md</u>			
24a. REC'D BY REGISTRAR <u>OCT 20 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

11228

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11544

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film C297 10/24/61 mk

11529

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takeana Park		c. LENGTH OF STAY IN 1b 3 hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chatham'sburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanatorium & Hosp		d. STREET ADDRESS 1444 W. 11th St. N.W.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ada Blanche Crouse		4. DATE OF DEATH 10 17 19 41		5. SEX F	
6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-11-73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John L. Crouse		14. MOTHER'S MAIDEN NAME Mary H. Sefton		12. CITIZEN OF WHAT COUNTRY? Am	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Washington Sanatorium & Hosp		17. INFORMANT Washington Sanatorium & Hosp	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 4 hrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-18-61	
EXAMINER'S NAME (Type) FRANK J. Broschart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Thurmont	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 10-20-61		22c. NAME OF CEMETERY OR CREMATORY United Brethren	
23. FUNERAL DIRECTOR E. L. Parker		24. REC'D BY REGISTRAR Arthur L. Hanna		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

VS. A15ME
SM 9/6D

11231

STATE OF TEXAS

COUNTY OF DALLAS

11231

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FEB 19 1901

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

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(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11545											
11530											
Item 21 Film G297 10/11/61 iwk											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Missouri b. COUNTY Missouri					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. LENGTH OF STAY IN b. 28 Days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Joseph					
3. NAME OF DECEASED (Type or print) Charles Morgan						d. STREET ADDRESS 807 North 25th Street					
5. SEX Male						4. DATE OF DEATH Month October Day 3 Year 19 61					
6. COLOR OR RACE White						8. DATE OF BIRTH November 21, 1894					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. AGE (In years last birthday) yrs. 66 IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant						10b. KIND OF BUSINESS OR INDUSTRY Office					
11. BIRTHPLACE (County & State, or foreign country) Missouri						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles M. Culver						14. MOTHER'S MAIDEN NAME Louella Elliot					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. 491-10-2075					
17. INFORMANT The Medical Records						17. INFORMANT The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 710.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Congestive Heart Failure DUE TO (c) Scleroderma INTERVAL BETWEEN ONSET AND DEATH 10 Hours 10 Months 1 Year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from September 5, 1961 to October 3, 1961 that (I) (we) last saw the deceased alive on October 3, 1961 and that death occurred at 11:50AM from the causes and on the date stated above.											
22a. SIGNATURE Thomas S. Vates Jr. M.D.											
22b. DATE SIGNED 10-3-61											
22c. PHYSICIAN'S NAME (Type) Thomas S. Vates Jr. M.D.											
22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal											
23b. DATE THEREOF 10/4/1961											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State) St. Joseph, Missouri											
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawlers Doss ADDRESS 1756 Pa. Ave. NW D.C.											
25a. REC'D BY REGISTRAR DATE OCT 5 '61											
25b. REGISTRAR'S SIGNATURE Arthur S. Hume											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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11546
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11531

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b Since 9/10/61		d. STREET ADDRESS 720 Dale Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kensington Gardens Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUIS MARSHALL CUVILLIER SR.		4. DATE OF DEATH Month October Day 24 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1882
9. AGE (in years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed Dental Surgeon		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Petersburg, Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Freeland		14. MOTHER'S MAIDEN NAME Augusta Marshall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-38-1431	
17. INFORMANT Mrs. Anna V. Cuvillier, 720 Dale Drive, SS., Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 14 YRS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB. 1961 to 23 OCT. 1961, that (I) (we) last saw the deceased alive on 23 OCT. 1961, and that death occurred at 5:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE L. Marshall Cuvillier, Jr.		22b. DATE SIGNED 10/24/61	
22c. PHYSICIAN'S NAME (Type) L. Marshall Cuvillier, Jr.		22d. ADDRESS 1407 Woodside Parkway, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 26, 1961	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Ziska		25a. REC'D BY REGISTRAR DATE OCT 25 '61	
25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc., Silver Spring, Md.		25c. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

Reg. Dist. No. **11532****11547****M**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN lb 3 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander, Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Matie Middle Last DARBY		4. DATE OF DEATH Month October Day 18 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5-1877
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin Dyson		14. MOTHER'S MAIDEN NAME Catherine Pyles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Address Dunbar Darby, Beallsville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Orthostatic pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease (c) arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH 3 days - 5 years 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 50 , to Oct 18 , 19 61 , that I last saw the deceased alive on Oct 16 , 19 61 , and that death occurred at 8:47 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John Fawcett M.D.			
PHYSICIAN'S NAME (Type) John Fawcett			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 20-1961	22c. NAME OF CEMETERY OR CREMATORY Monocacy	22d. LOCATION (City, town, or county) (State) Beallsville, Md
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR Barneville, Md.	24b. REGISTRAR'S SIGNATURE Clairmont S. House

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Page 4

hours after death.

The law requires that the death certificate be executed within 72 hours after death.

VS A15 (4)

TSM 9/58

11527

Montgomery

Germanston

3 yrs

Belleville, Mo

The Montgomery Nursing Home

Marie

Bennie White

Sept. 7-1877

Hawesville

Maryland

Benjamin Tyson

California Texas

London, Ontario, Canada

John Carroll

Sept. 10-1921
Hawesville

Hawesville, Mo

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11548 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11533

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS <u>8906 Pearma Ave</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>La Verne Constance Davis</u>			4. DATE OF DEATH <u>Oct 8 1961</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>col</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3-6-31</u>		
9. AGE (In years last birthday) <u>30</u> yrs.			10. IF UNDER 1 YEAR Months Days		
11. IF UNDER 24 HRS. Hours Min.			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>S+10 Store</u>		
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Gabe Tracy</u>			14. MOTHER'S MAIDEN NAME <u>Sadie Wellman's</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes, give number or dates of service)		
17. INFORMANT <u>Police Record</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>981X Throacic hemorrhage</u> DUE TO (b) <u>Bullet wound Thru aorta</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Repeated Shot by husband</u>					
20c. TIME OF INJURY Month, Day, Year <u>5:10 PM 10-8 1961</u>					
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>					
20f. (City or town) <u>Silver Spring Montg md</u> (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county) <u>10-8-61</u>					
22a. BURIAL, CREMATION, REBURY (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>10/13/61</u>		<u>Mt. Zion.,</u>	
22d. LOCATION (City, town, or country)		22e. REGISTRAR'S SIGNATURE			
<u>Silver Spring, Md.</u>		<u>Arthur S. Kraus</u>			
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 13 '61</u>	
DATE		DATE		DATE	

MEDICAL CERTIFICATION

11532

11532

law require:

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11549

CERTIFICATE OF DEATH

11534

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 39 Days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center				d. STREET ADDRESS 14 Grafton Street			
3. NAME OF DECEASED (Type or print) RUTH JACOBS DAVIS				4. DATE OF DEATH Month October Day 16 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 6, 1910	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 51 Days 16 Hours 16 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary for Mr. Davis		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. MOTHER'S MAIDEN NAME Mary O. Shipley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unavailable			
17. INFORMANT The Medical Record				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized cachexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Widespread metastatic disease from bronchogenic carcinoma DUE TO (c) Generalized cachexia			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 3 months 15 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that she (this hospital) attended the deceased from September 7, 1961 to October 16, 1961 , that we last saw the deceased alive on Oct. 16, 1961 , and that death occurred at 1:45 PM from the causes and on the date stated above.							
22a. SIGNATURE J. David Heywood, M.D.				22b. DATE SIGNED 10/16/61			
22c. PHYSICIAN'S NAME (Type) J. David Heywood, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/20/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				25. REC'D BY REGISTRAR OCT 18 '61			
25a. ADDRESS 2901 14th St. N.W. Washington 9, D.C.				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO SPIRIT OR ATTENDING PHYSICIAN: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

11511

M

A

Montgomery

Attended

32 days

Guest, June 12

The Clinical Center

11 Grafton Street

x

61

October 16

DAVID

JACOB

WIFE

x

January 6, 1910

Female

Montgomery

Secretary, Dr. J. Davis

William F. Jacobs

Harry C. Shiley

The Medical Record

Unavailable. The Clinical Center, Bethesda 16, Maryland

No

Generalized convulsions

3 months

Widespread metastatic disease from bronchogenic carcinoma

12 months

continued

x

x

Oct. 16, 61

September 7, 61 October 16, 61

12/16/61

x

The Clinical Center, National Institutes of Health, Bethesda 16, Md.

J. David Howard, M.D.

David Howard

Butler

10/17/61

Casey Hill Cemetery

10/17/61

The S. H. Jones Co. 2901 Main St. S.E. Washington 25, D.C.



VS. A15ME
5M 9/60

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

CO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and its designated agent, prior to burial, emation, or removal, and in any event within 72 hours after death.

11220

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11551

CERTIFICATE OF DEATH

11536

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN lb D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park, d. STREET ADDRESS 7900 Cole Avenue, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Delia First Middle Last Dennean 4. DATE OF DEATH October 5, Month Day Year 19 61		9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH Dec. 6, 1878 11. BIRTHPLACE (County & State, or foreign country) New York City, N.Y. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph McCoy 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no 16. SOCIAL SECURITY NO. 17. INFORMANT Margaret Ward Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1961 to Oct. 1961, that (I) (we) last saw the deceased alive on Oct 5 1961, and that death occurred at 2:28M, from the causes and on the date stated above.			
22a. SIGNATURE Louis M. Jimal 22c. PHYSICIAN'S NAME (Type) Louis M. Jimal M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 4008 Bladensburg Road, Cottage City, Md. 22b. DATE SIGNED 10-5-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/1961	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln		23d. LOCATION (City, town or county) (State) Bladensburg, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		25a. REC'D BY REGISTRAR DATE OCT 9 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

Dr. Broschart notified

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11551

11551

Montgomery

Tolson

W.A.

Tolson

Washington Sanitation and Hospital

1900 60th Avenue

Letter

Letter

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Letter

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Dec. 6, 1978

12

Letter

New York City, N.Y.

Letter

Letter

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Letter

12-11-78

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12
FOR STATE
HEALTH DEPT.

11552
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11537

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>			
c. LENGTH OF STAY IN b. <u>DOA</u>				d. STREET ADDRESS <u>9915 Big Rock Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joan Marie Devost</u>				4. DATE OF DEATH <u>10-10-1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-18-59</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>22</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Valmore Devost</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Workman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes give year or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Father</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VIRAL (INTERSTITIAL) PNEUMONIA</u> 492X DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (c) <u></u> (e), stating the underlying cause last. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschack</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHACK</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or country) <u>10-10-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-13-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR <u>F. J. Collins</u> ADDRESS <u>WASH. D.C.</u>				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
FRANCIS J. COLLINS 3821 14TH. ST. N.W.				DATE <u>OCT 13 '61</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11553									
11538									
1. PLACE OF DEATH <u>BELMONT NURSING HOME</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>MONTGOMERY</u>					a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				
c. LENGTH OF STAY IN lb. <u>5 MO.</u>					d. STREET ADDRESS <u>6412 - BALFOUR DRIVE</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BELMONT NURSING HOME</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>ELLEN (NELLIE) DICKSON</u>					4. DATE OF DEATH <u>OCT 6 1961</u>				
5. SEX <u>FEMALE</u>					6. COLOR OR RACE <u>WHITE</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>10-25-75</u>				
9. AGE (In years last birthday) <u>85</u> yrs.					IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A. NEW YORK CITY</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>RICHARD OWENS</u>					14. MOTHER'S MAIDEN NAME <u>MC GLYNN - ANN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>NONE</u>				
17. INFORMANT <u>H. Mc. Donnell</u>					Address <u>BELMONT NURSING HOME 17220 COLESVILLE RD S.S.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> (c) <u>DISKASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u> DUE TO <u>INTERVAL BETWEEN ONSET AND DEATH (5 min)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>7/9/61</u> to <u>10/6/61</u> , that (I) (we) last saw the deceased alive on <u>10/6/61</u> , and that death occurred at <u>6</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>John P. Martin</u>					22b. DATE SIGNED <u>10/6/61</u>				
22c. PHYSICIAN'S NAME (Type) <u>JOHN P. MARTIN M.D.</u>					22d. ADDRESS <u>4164 - Southend Rd. Rockville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>10-9-61</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>					23d. LOCATION (City, town or county) (State) <u>Montgomery Maryland</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>					25a. REC'D BY REGISTRAR <u>Arthur L. Evans</u>				
25b. REGISTRAR'S SIGNATURE <u>3821-14th St. N.W. Wash. D.C.</u>					DATE <u>OCT 9 '61</u>				

11553

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Handwritten notes, possibly "Hunt 2012" and "1912 - 1913" with a small 'x' mark.

(Hunt)

Handwritten note: "Hunt 2012"

Large block of faint, mostly illegible handwritten text.

Bottom section of handwritten text, including a date "10-1-11" and other notes.

3 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3 1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11589

1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Poolesville		c. LENGTH OF STAY IN 1b DO A		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Poolesville		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Md R-107 Poolesville				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alfred Carroll Dorsey		First Middle Last		4. DATE OF DEATH Oct 9 1961		Month Day Year	
5. SEX male	6. COLOR OR RACE Cal.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3-30-1912	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Dorsey				14. MOTHER'S MAIDEN NAME Martha Wood			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give number or date of service)		17. INFORMANT Hospital record:		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination 8-25X DUE TO Rupture of heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Crushed Chest PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden Sudden
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto involved in accident					
20c. TIME OF INJURY Month, Day, Year 1:39 a.m. 10-9 1961	2dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Md R-107		20f. (City or town) (County) (State) Poolesville Montg md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) FRANK J. Broschart				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		10-9-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/12/61		22c. NAME OF CEMETERY OR CREMATORY Warren Chapel Cemetery, Martinsburg, Md.	
23. FUNERAL DIRECTOR Robert L. Sworden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR 10-17-61	
				24b. REGISTRAR'S SIGNATURE Arthur L. House			

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Health record:
Date: 1900

Form 1000

U. S. Army, Medical Department, Washington, D. C.

Serial 11554

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11555

11540

1. PLACE OF DEATH a. COUNTY <u>Montg,</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germantown Rural</u>		c. LENGTH OF STAY IN 1b <u>80yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germantown Rural</u>	
		d. STREET ADDRESS <u>/</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Rebecca</u> Last <u>Dunn</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>20th</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 1st 1879</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Leonard Marth</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Gruesendorf.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Charles Howard Dunn, Germantown, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>420.0</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis Heart Disease</u> (a), stating the underlying cause listed, (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>Oct 19</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct 16</u> , 19 <u>61</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Vernon S. Masters</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Germantown Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-23-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Neelsville. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner.</u>		25a. REC'D BY REGISTRAR <u>Oct 24 61</u>	
ADDRESS <u>Gaithersburg. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Walter S. Thomas</u>	

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U.S. DEPARTMENT OF COMMERCE
BUREAU OF COMMERCE
WASHINGTON, D.C.

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MONTGOMERY STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11556
CERTIFICATE OF DEATH
11541

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 4319 Alton Pl.,	
3. NAME OF DECEASED (Type or print) First George Middle G. Last Duvall		4. DATE OF DEATH Month 10 Day 2 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/17/78
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 10 Days 2 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman-Ref.		10b. KIND OF BUSINESS OR INDUSTRY Woodward & Loth	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Duvall		14. MOTHER'S MAIDEN NAME Mary Ann Perry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Percy D. Duvall-Son-Same 2d		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease. DUE TO (c) Prostatic Cancer with Metastases		INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 year 34 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis Severe Right Hip.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19... to 1961 , 19..., that (I) (we) last saw the deceased alive on 10/2 , 19 61 , and that death occurred at 9 A.M. from the causes and on the date stated above.			
22a. SIGNATURE P. P. Andrews		22b. DATE SIGNED 10-2-61	
22c. PHYSICIAN'S NAME (Type) P. P. ANDREWS		22d. ADDRESS 4801 FESSENDEN ST. N.W. WASHINGTON D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town or county) (State) Bethesda, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 4 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

11256



Robert A. Pughrey, Bethesda, Maryland
10/5/61
Mr. John Comstock
Bethesda, Maryland

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A1SME
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
11557 11542											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. LENGTH OF STAY IN 1b <u>2 1/2 hrs.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>						e. STREET ADDRESS <u>1 Box 93</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Othe Early</u>						4. DATE OF DEATH Month Day Year <u>Oct. 30 1961</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1932</u>		9. AGE (In years last birthday) <u>29</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver milk Co.</u>						11. BIRTHPLACE (State or foreign country) <u>Maryland</u>					
13. FATHER'S NAME <u>Glen Early</u>						14. MOTHER'S MARRIAGE NAME <u>Martha J. Early</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>218-30-8646</u>					
17. INFORMANT <u>Ma deline Early</u>						18. ADDRESS <u>As above</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO (b) <u>Ruptured Berry aneurysm middle cerebral artery</u> DUE TO (c) <u>7 hr</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
2De. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschak</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHAK</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) <u>10-31-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov. 2, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>		22d. LOCATION (City, town, or country) (State) <u>Nr. Myersville, Md. Fred. Co</u>			
23. FUNERAL DIRECTOR <u>Paul F. Bittle</u>						24a. REC'D BY REGISTRAR <u>NOV 2 '61</u>					
ADDRESS <u>Paul F. Bittle, Myersville, Md.</u>						24b. REGISTRAR'S SIGNATURE <u>William S. Finney</u>					

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U.S. GOVERNMENT PRINTING OFFICE: 1964

FROM THE JEFF. S. VOL. DEPT.

RECEIVED BY THE DIRECTOR, FBI, 11/1/54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) STATE Virginia b. COUNTY Arlington ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		d. STREET ADDRESS 2819 Key Boulevard	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillian Middle Ruth Last Edwards				4. DATE OF DEATH Month October Day 6 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1896	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting Examiner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (County & State, or foreign country) Maryland		9. AGE (In years last birthday) yrs. 65 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME Vincent Powers				14. MOTHER'S MAIDEN NAME Rose Vermillion			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				17. INFORMANT The Medical Record Unascertainable The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic myelogenous leukemia DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 10 hours 3 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Sept. 11, 1961 to October 6, 1961 , that he (we) last saw the deceased alive on October 6, 1961 , and that death occurred at 7:11 PM from the causes and on the date stated above.							
22a. SIGNATURE Frederick H. Welland, M.D.				22b. DATE SIGNED 10/8/61			
22c. PHYSICIAN'S NAME (Type) Frederick H. Welland, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-12-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Benge				25a. REC'D BY REGISTRAR OCT 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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11-10-12-11
The Honorable James E. ...
Washington, Virginia

Washington, D.C.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11559 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11544

12
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in 1b <u>4 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1104 Dennis Ave</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1104 Dennis Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Joseph Carl Eggleston</u>		4. DATE OF DEATH <u>Oct 25 1961</u>		5. SEX <u>Male</u>									
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-1906</u>									
9. AGE (In years last birthday) <u>55</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wash. machine repair - Self-employed Va</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Alexander Eggleston</u>									
14. MOTHER'S MAIDEN NAME <u>Virginia C. Hepler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-09-5374</u>									
17. INFORMANT <u>Winona Eggleston (wife)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u> (b) <u>Shot gun wound</u> (c) <u>976X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malignant brain tumor</u>													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted shot gun wound</u>											
20c. TIME OF INJURY Month, Day, Year <u>8:45 p.m. 10-25-1961</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>home</u>									
20f. (City or town) <u>Silver Spring</u>		20g. (County) <u>Montg</u>		20h. (State) <u>md</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		EXAMINER'S NAME (Type) <u>FRANK J. BROSCHART</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/28/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedarwood Cemetery</u>									
22d. LOCATION (City, town, or country) (State) <u>Shennandoah Co. Virginia</u>		23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>OCT 27 '61</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hiana</u>		24c. ADDRESS <u>8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Maryland</u>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

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1
FOR STATE
HEALTH DEPT.

1
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11545

Item 11 Film C297 10/23/61 mh

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>50 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5108 Wilson Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Frank Engert</u>				4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-4-1910</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School bus</u>		9. AGE (In years last birthday) <u>51</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>UNK. Texas ?</u>	
13. FATHER'S NAME <u>UNK.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNK.</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>UNK.</u>			
17. INFORMANT <u>HOSPITAL RECORDS.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO (b) <u>Ruptured esophageal Varices</u> DUE TO (c) <u>Cirrhosis of Liver</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broscham</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broscham</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>10-17-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 19, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		22d. LOCATION (City, town, or country) (State) <u>WHEATON, MD.</u>	
23. FUNERAL DIRECTOR <u>W. W. Taltavull</u>				24a. REC'D BY REGISTRAR <u>3603-1, 11th ST NW WASH DC 10</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

0324



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11561 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11546

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Cherry Chase</u>		d. STREET ADDRESS <u>14008 Laird Place</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4008 Laird Place</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Engineer Lee Fallon</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-1908</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineering</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leo H. Fallon</u>				14. MOTHER'S MAIDEN NAME <u>Marguerite Barnette</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW 2</u>		16. SOCIAL SECURITY NO. <u>577-46-3999</u>		17. INFORMANT <u>Cecily Fallon (wife) Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-27-61</u>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/31/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR ADDRESS <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 31 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Cecilus S. Kears</u>	

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Report of the Committee on the
State of the Union, 1901

1
FOR STATE
HEALTH DEPT.

Items 18&21 Film 299 17-1-61
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11562 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11547

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Silver Spring</u>		d. STREET ADDRESS <u>18412 Ramsey Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8412 Ramsey Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Doris Overton Fernandez</u>				4. DATE OF DEATH <u>Oct 14 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>2-25-07</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>19</u> Mln. <u>61</u>		11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Unknown Overton</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Spruill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-26-9210</u>		17. INFORMANT <u>Jack Mettler (son)</u> Address <u>12116 Foley St Silver Spring md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Barbiturate poisoning</u> 871.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-15-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/17/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>				24a. REC'D BY REGISTRAR <u>OCT 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11563

11548

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY in 1b <u>41 hrs</u>		
d. NAME OF HOSPITAL or INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>			e. STREET ADDRESS <u>1 Oakcrest Trailer Ct</u> <u>But</u>		
3. NAME OF DECEASED (Type or print) <u>Baby</u> <u>Fields</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>9</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR or RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1961</u>		9. AGE (In years last birthday) yrs. <u>41</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>			10b. KIND OF BUSINESS or INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Sterven L. Fields</u>		
14. MOTHER'S MAIDEN NAME <u>ILM Payne</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		
16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>Hosp. Record.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory FAILURE</u> 760.0 DUE TO (b) <u>Multiple Cerebral petechial Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>-</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/7</u> <u>1961</u> to <u>10/9</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>10/9</u> <u>1961</u> , and that death occurred <u>24 hr</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Dr. W. Paulman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/9/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>10/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>	
23d. LOCATION (City, town or county) <u>BETHESDA, MARYLAND</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA C. CARTER, ADMIN.</u> (PER F.B.)		ADDRESS <u>OLD GEORGETOWN RD.</u> <u>BETHESDA, MD.</u>		25a. REC'D BY REGISTRAR <u>OCT 16 '61</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined and within 24 hours after death, page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/59

Items 18-21 film 300
11-10-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11564

11549

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
c. LENGTH OF STAY in 1b <u>1 day</u>				d. STREET ADDRESS <u>8907 Kensington Pkway</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>KATHARINE FIGUEROA</u>		4. DATE OF DEATH <u>October 29 1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 23, 1922</u>		9. AGE (In years last birthday) <u>34</u>		IF UNDER 1 YEAR: Months <u>34</u> Days <u>34</u> Hours <u>34</u> Min. <u>34</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>SANTURCE, PUERTO RICO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALCIDES FIGUEROA</u>				14. MOTHER'S MAIDEN NAME <u>KATHARINE SHEIBLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes give number or date of service)</u>		17. INFORMANT <u>(AUNT)</u> <u>SARA FIGUEROA</u>		Address <u>AS ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic barbiturate poisoning</u> 871.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>871.9</u> DUE TO (c) <u>871.9</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Reported that she had been taking second regularly during past year. Was driving auto 10/27/61 when she sideswiped two cars. She was not injured. Taken to hosp. under influence of barbiturate</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>---</u>		20g. (County) <u>---</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>10-29-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 2 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Shelton, Maryland</u>	
23. FUNERAL DIRECTOR <u>H. Don. DeVol</u>		ADDRESS <u>2224-Wis. Ave NW</u>		24a. REC'D BY REGISTRAR <u>NOV 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kane</u>	

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

Reg. Dist. No. 11550

11563

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2424 Ross Rd		d. STREET ADDRESS 2424 Ross Rd	
3. NAME OF DECEASED (Type or print) First HATTIE Middle FISCHGRUND Last FISCHGRUND		4. DATE OF DEATH Month OCT Day 19 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 19, 1887
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) NEW YORK
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ROBERT SASSERATH	
14. MOTHER'S MAIDEN NAME ROSA ROSENZWEIG		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. —		INFORMANT Address 2303 E.W. HIGHWAY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE ARTERIOSCLEROTIC DUE TO (c) HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 6 HOURS 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1 , 19 50 , to OCT 19 , 19 61 , that I last saw the deceased alive on OCT 19 , 19 61 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. N. Sugar M.D.		ADDRESS (Street, city or town, state) 4637 EASTERN AVE WASHINGTON 18, DC	
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR		DATE SIGNED OCT 19, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-20-61	
22c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON DC	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Sanyansky		ADDRESS 3501-14th NW	
24a. REC'D BY REGISTRAR OCT 23 '61		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
BIRTH: [illegible]
DEATH: [illegible]
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

1

CERTIFICATE OF DEATH

Reg. Dist. No.

11551

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8405-SPENCER COURT		d. STREET ADDRESS 8405 SPENCER COURT	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SAMUEL Middle FISHER Last FISHER		4. DATE OF DEATH Month OCTOBER Day 12 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 10, 1897
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR: Months 6 Days 4 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10b. KIND OF BUSINESS OR INDUSTRY LATVIA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNION WOLF FISHER		14. MOTHER'S MAIDEN NAME HANNAH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 578-482-793	
17. INFORMANT HERMAN FISHER		Address 8153 E. BEACH DR. N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO Over 2 years (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 7 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 15 , 19 60 , to OCT 5 , 19 61 , that I last saw the deceased alive on OCT 5 , 19 61 , and that death occurred at 6 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Washington, D.C. DATE SIGNED 2601-16th Street, N.W.			
ACTUAL SIGNATURE Warren D. Brill, M.D.		M.D. 2601-16th Street, N.W.	
PHYSICIAN'S NAME (Type) Warren D. Brill, M.D.		Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-13-61	22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN	22d. LOCATION (City, town, or county) (State) FALLS CHURCH, VA.
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Langewiesch + Assoc.		24a. REC'D BY REGISTRAR OCT 16 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kenna

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11567											
11552											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence if not a resident) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> Talbot					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> Easton					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>						d. STREET ADDRESS <i>9293 New Hampshire Ave</i>					
3. NAME OF DECEASED (Type or print) <i>Baby Girl Fleck</i>						4. DATE OF DEATH <i>Oct 1 1961</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 30 1941</i>		9. AGE (In years last birthday) <i>19</i> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME <i>Judith Fleck</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Congenital Heart disease</i> 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 30, 1961</i> to <i>Oct 1, 1961</i> , that (I) (we) last saw the deceased alive on <i>Oct 1, 1961</i> and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Robert P. Warthen</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>Robert P. Warthen</i>						22d. ADDRESS <i>3716 Howard Ave Kensington Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <i>Oct. 3, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fair Lincoln Crematory</i>		23d. LOCATION (City, town or county) (State) <i>Prince Geo. Co. Md.</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Wallers</i> ADDRESS <i>254 Canal St. N.W. D.C.</i>						REC'D BY REGISTRAR <i>Oct 4 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

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FOR STATE
HEALTH DEPT.

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

11568
11553
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 19 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mansion Drive				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS Mansion Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Katie Mae Flester				4. DATE OF DEATH October 5 19 61			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 28, 1893	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress - Retired-Mayflower Hotel		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 67 yrs.		11. BIRTHPLACE (State or foreign country) Washington D.C.	
13. FATHER'S NAME Lucian Lovelace				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No				14. MOTHER'S MAIDEN NAME Ida Sidnor			
16. SOCIAL SECURITY NO. 577-03-0613				17. INFORMANT Mrs. Edmund P. Hammett			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCHART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 10-5-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/61		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or country) (State) Montgomery County, Maryland	
23. FUNERAL DIRECTOR Raymond A. Ziska Warner E. Pumphrey, Inc.				24a. REC'D BY REGISTRAR OCT 9 '61			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11569 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11554

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Mar Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Mar Park</u>			
c. LENGTH OF STAY IN 1b <u>14 yrs</u>				d. STREET ADDRESS <u>5802 Augusta La - Wash 16</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5802 Augusta Lane - Wash 16</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Leslie Elizabeth Foller</u>				4. DATE OF DEATH Last <u>Oct</u> 11 1961			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-30-1855</u>	
9. AGE (In years last birthday) <u>106 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>			
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Daniel Musselman</u>				14. MOTHER'S MAIDEN NAME <u>- - -</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>- - -</u>			
17. INFORMANT <u>Helen F. Reddick - Glen 2</u>				Address <u>- - -</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration of gastric contents</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of breast with widespread metastasis</u> <u>unk</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>Less than 1hr</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Date Signed <u>10-11-61</u>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>10-13-1961</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>				22d. LOCATION (City, town, or country) (State) <u>Suitland, Md.</u>			
23. FUNERAL DIRECTOR <u>Joseph Gaudin & Son, Inc.</u>				24a. REC'D BY REGISTRAR <u>1756 B. Ave. N.W.</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>				DATE <u>OCT 16 '61</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each of the papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
11570					11555					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY MONTGOMERY					a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY					b. COUNTY MONTGOMERY					
c. LENGTH OF STAY in 1b 20 MIN					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 SILVER SPRING					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL					d. STREET ADDRESS 15829 COLESVILLE RD					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			Month		Day		
First GROVER			Middle CLEVELAND			Last FORD		10 17 61		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.			
m	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	4-19-13	48 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) VIRGINIA				
13. FATHER'S NAME MARION FORD			12. CITIZEN OF WHAT COUNTRY? U.S.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)			14. MOTHER'S MAIDEN NAME Maggie Dudley				
17. INFORMANT Hospital Records			Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Congestive heart failure Chronic myocarditis Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 1 wk. yrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
19				11/1/61		19		10/17/61		
21. I certify that (I) (this hospital) attended the deceased from 11:00 AM to 10/17/61, that (I) (we) last saw the deceased alive on 10/17/61, and that death occurred at 11:00 AM, from the causes and on the date stated above.										
22a. SIGNATURE C.H. Wiggin				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/17/61		
22c. PHYSICIAN'S NAME (Type) C.H. Wiggin				22d. ADDRESS Sandy Spring, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10-18-61		23c. NAME OF CEMETERY OR CREMATORY Lee Funeral Home		23d. LOCATION (City, town, or county) Washington & Co		23e. LOCATION (City, town, or county) Clifton Forge, Va		
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS Washington & Co		25a. REC'D BY REGISTRAR DATE OCT 19 '61		25b. REGISTRAR'S SIGNATURE Charles E. House		

2025

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11571

11556

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 5415 Conn. Ave. Apt. 423	
3. NAME OF DECEASED (Type or print) First ROSE Middle RIZZO Last GAUZZA		4. DATE OF DEATH Month Oct. Day 27 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1879
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Rizzo		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Roy Gauzza (son)		Address 10907 Jollyway Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 17 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 23, 1960 to October 27, 1961 , that (I) (we) last saw the deceased alive on October 26, 1961 , and that death occurred at 3:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James M. Loftus		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JAMES M. LOFTUS M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10 30 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Sawicki		25a. REC'D BY REGISTRAR OCT 31 '61	
25b. REGISTRAR'S SIGNATURE Carlton S. Kane		25c. REGISTRAR'S SIGNATURE	

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
FEDERAL BUREAU OF INVESTIGATION
CENTRAL OFFICE OF DEATH

1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11572 CERTIFICATE OF DEATH 11557

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 73 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Florida b. COUNTY Hollywood c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48x-3 d. STREET ADDRESS 3311 Southwest 36th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Nancy Louise Gibson			4. DATE OF DEATH Month Day Year October 5 - 17 19 61		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1950	9. AGE (In years last birthday) 11 yrs.	IF UNDER 1 YEAR Months Days 11 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY None		
11. BIRTHPLACE (County & State, or foreign country) Ohio			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Kenneth Gibson			14. MOTHER'S MAIDEN NAME Ruth Meager		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT The Medical Record			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Pancytopenia DUE TO (c) Bone Marrow aplasia, Acquired		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 days 7 months 7 months		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from August 5, 1961 to October 17, 1961 , that (I) (we) last saw the deceased alive on October 17, 1961 , and that death occurred at 9:05 p.m. from the causes and on the date stated above.					
22a. SIGNATURE Edward S. Henderson 22c. PHYSICIAN'S NAME (Type) EDWARD S. HENDERSON, M.D.			22b. DATE SIGNED 10/18/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 10/19/61		
23c. NAME OF CEMETERY OR CREMATORY Wash D.C.			23d. LOCATION (City, town or county) (State) W. Hollywood, Fla.		
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co Inc			25a. REC'D BY REGISTRAR DATE OCT 20 '61		
25b. REGISTRAR'S SIGNATURE Arthur S. Kline					

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Washington State Penitentiary

Prisoners of War

Washington State Penitentiary

Prisoners of War

Washington State Penitentiary

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Washington State Penitentiary

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Washington State Penitentiary

Prisoners of War

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11574

CERTIFICATE OF DEATH

11559

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Missouri b. COUNTY Rich Hill c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 320 Cedar Street d. STREET ADDRESS 320 Cedar Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Larry Joe Gordon		4. DATE OF DEATH Month October Day 1 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1940
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing	9. AGE (In years last birthday) 20 yrs. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. 2
11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson Gordon		14. MOTHER'S MAIDEN NAME Sue Denayer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unavailable	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 754.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Disease (Tetralogy of Fallot) DUE TO (c) 20 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 1 (this hospital) attended the deceased from September 20, 1961 to October 1, 1961 , that 1 (we) last saw the deceased alive on October 1, 1961 , and that death occurred 11:00 PM from the causes and on the date stated above.			
22a. SIGNATURE Dean T. Mason		22b. DATE SIGNED 10/2/61	
22c. PHYSICIAN'S NAME (Type) DEAN T. MASON, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		23b. DATE THEREOF 10/3/61	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town or county) (State) Rich Hill, Missouri	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR OCT 4 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Longevity

Age

11 days

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The Clinical Center, Bethesda, Md.

300 South Street

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Responsible for Clinical Center, Bethesda, Md.

General Vascular Assistant

Congenital Heart Disease (Theory of Relief) 10 years

October 1

October 20 of October 1

11:00

DR. T. MASON, M.D.

The Clinical Center, Bethesda, Md.

Surgeon General, U.S. Army

Robert A. Humphrey, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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11560
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 40</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10106 GEORGIA AVE</u>		d. STREET ADDRESS <u>10106 GEORGIA AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IRVING</u> Middle <u>-</u> Last <u>GORIN</u>		4. DATE OF DEATH Month <u>10</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE-15-1905</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHEET METAL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BARRY GORIN</u>		14. MOTHER'S MAIDEN NAME <u>LEAH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>578-46-528</u>	
17. INFORMANT <u>NORMAN GORIN</u> Address <u>1311-29 1st St. N.W. DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>10/25</u> 19 <u>61</u> , that <u>we</u> last saw the deceased alive on <u>10/21</u> 19 <u>61</u> , and that death occurred at <u>8:30</u> A. M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John J. Rheingold M.D.</u>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>JACK J. RHEINGOLD</u>		22d. ADDRESS <u>1301 18th St. N.W. Wash. DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/27/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>D.C. ROGGE Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Wash., DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Josephine Home</u> ADDRESS <u>4217-9th St. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 30 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. Harris</u>	

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County of ... State of ...
I, ... of the County of ... State of ...
do hereby certify that ...

is the true and correct copy of the ...
as the same appears from the records of the ...

County Clerk of said County.
Witness my hand and seal of office this ... day of ... 1887.

...
County Clerk

Attest my hand and seal of office this ... day of ... 1887.
County Clerk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11576 CERTIFICATE OF DEATH 11561											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania Md. b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montdale Silver Spring 22				d. STREET ADDRESS 205 Granville Drive 811 Brisbane St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Helen			First Middle Last Kathryn			4. DATE OF DEATH October 7 1961			Month Day Year		
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1917		9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Hugh Pidgeon						14. MOTHER'S MAIDEN NAME Helen/Kathryn/ Emma Langsford					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. 577 14 5465		17. INFORMANT Richard D. Gottlieb Same as #2 above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 DUE TO Gastrointestinal Hemorrhage Conditions, if any, which gave rise to immediate cause (b) Cirrhosis, Liver Laënnec's 5810 Years (a), stating the underlying cause last. (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) (State)	
21. I certify that (A) (this hospital) attended the deceased from Sept 21, 1961 to Oct 7, 1961 that (B) (we) last saw the deceased alive on Oct 7, 1961, and that death occurred at 2:40 AM from the causes and on the date stated above.											
22a. SIGNATURE Robert E. De Forest M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED October 7, 1961			
22c. PHYSICIAN'S NAME (Type) Robert E. De Forest						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10 Oct 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington		(State) Va.	
24a. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey						ADDRESS Warner E. Pumphrey Funeral Home, Silver Spring, Md.		25a. REC'D BY REGISTRAR OCT 10 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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11378

11378

CERTIFICATE OF DEATH

State of New York

County of ...

In the City of ...

Deceased (Name)

Age ...

Sex ...

Color ...

Occupation ...

Married ...

Place of Birth ...

Usual Residence ...

Present Residence ...

Time of Death ...

Place of Death ...

Cause of Death ...

Medical History ...

History of Present Illness ...

Examination of Body ...

Postmortem Examination ...

Disposition of Body ...

Signature of Physician ...

Signature of Coroner ...

Signature of Registrar ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

FOR STATE
HEALTH DEPT.

M

VS. A15ME
SM 9/60

MEDICAL CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11577

11562

1. PLACE OF DEATH a. COUNTY Mont. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Mont. Co.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg		d. STREET ADDRESS R.F.D. #3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gloria Natalie Gray alias Cromwell				4. DATE OF DEATH Oct. 14 1961			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1926		9. AGE (In years last birthday) 35 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private individuals.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Gray				14. MOTHER'S MAIDEN NAME Louise Breckinridge			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Richard S. Gray / Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exsanguination</i> 823X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>Rupture of Aorta</i> (c) <i>Crushed chest & fracture of neck</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>Sudden</i> <i>Sudden</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>passenger in car which struck tree</i>					
20c. TIME OF INJURY Hour <i>5:50</i> p.m. <i>10-14</i> 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>Rockville, Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschaw</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>FRANK J. Broschaw</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<i>10-15-61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/19/61		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park., Rockville, Md.	
23. FUNERAL DIRECTOR <i>Robert L. Snowden</i>				22d. LOCATION (City, town, or country) (State) Rockville, Md.		24a. REC'D BY REGISTRAR OCT 20 '61	
				24b. REGISTRAR'S SIGNATURE <i>Charles L. Hume</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11578

11563

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 57 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS Gaithersburg							
3. NAME OF DECEASED (Type or print) First Charles Middle Jacob Last Green				4. DATE OF DEATH Month Oct. Day 13 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph L. Green				14. MOTHER'S MAIDEN NAME Catherine R. Weber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-22-2134		17. INFORMANT Mrs. Charles J. Green		Address Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) PULMONARY INFARCTION DUE TO (c) ARTERIO SCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIO SCLEROSIS, EMPHYSEMA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 19____, to Oct 13 19 61 , that (I) (we) lost saw the deceased alive on Oct 13 19 61 , and that death occurred 7:40 PM , from the causes and on the date stated above.							
22a. SIGNATURE G. F. Meadors, MD				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) G. F. MEADORS, MD				22d. ADDRESS DAMASCUS, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 16, 1961		23c. NAME OF CEMETERY OR CREMATORY Wesley Grove		23d. LOCATION (City, town, or county) (State) Woodfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 18 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11579

11564

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN, 1b <u>39 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write, RURAL and give nearest town) <u>Silver Spring 24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>806 Child Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Charles</u> First <u>Hackman</u> Middle <u>Charles</u> Last				4. DATE OF DEATH <u>Oct</u> Month <u>31</u> Day <u>1961</u> Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 14 1882</u>		9. AGE (In years lost birthday) <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inventor Enigma</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicago, Ill</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Claus Hackman</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Schultz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-4840</u>		17. INFORMANT <u>Mrs Lorraine Hackman</u> Address <u>509 Child Ave Silver Spring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Arteriosclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 attacks</u> DUE TO (c) <u>11/2/56 - 7/3/22/57</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10/31/61</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/17/48</u> to <u>10/31</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/29</u> , 19 <u>61</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard I Morse</u> M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Howard I Morse M.D.</u>	
22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Ziska</u> ADDRESS <u>8434 Georgia Avenue</u>				25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
				DATE <u>NOV 2 '61</u>			

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CERTIFICATE OF DEATH

1157

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[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. There are also sections for the attending physician and the funeral home. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

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2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11580
CERTIFICATE OF DEATH

11565

1. PLACE OF DEATH e. COUNTY Montgomery M		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D.C. b. COUNTY Washington, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
c. LENGTH OF STAY IN lb 10 days		d. STREET ADDRESS 1835 A. St. S.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San & Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Winnie Ida Hall		4. DATE OF DEATH Month 10 - Day 28 Year 1961	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1888
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henley		14. MOTHER'S MAIDEN NAME Martha McDonald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis & Pulm. Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Coronary Insufficiency - with narrowing DUE TO (c) Myocardial Infarction - Recent PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes Mellitus + Large Kidneys INTERVAL BETWEEN ONSET AND DEATH Terminal ? Years ? 3-4 wks.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 18, 1961 to Oct 28, 1961 , that (I) last saw the deceased alive on Oct 27, 1961 , and that death occurred at 755 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert A. Hare		22b. DATE SIGNED 10/28/61	
22c. PHYSICIAN'S NAME (Type) Robert A. Hare, M.D.		22d. ADDRESS 7600 Carroll Ave. T.P., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 31, 1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters		25a. REC'D BY REGISTRAR OCT 31 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume		25c. ADDRESS	

11581

CERTIFICATE OF DEATH

Reg. Dist. No.

11566

1. PLACE OF DEATH COUNTY Montgomery M		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gladys Middle G. Last Halterman		4. DATE OF DEATH Month October Day 19 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/94
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Lost City, W. Virginia
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME J. F. Garrett	
14. MOTHER'S MAIDEN NAME Nettie Miley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		INFORMANT Roy Halterman-Item# 2	
17. ADDRESS Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent Bronchial Pneumonia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lymphocytic Leukemia DUE TO (c) 16 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/14/61 to 10/20/61 , that I last saw the deceased alive on 10/14/61 , and that death occurred at 10/20/61 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 10/20/61			
ACTUAL SIGNATURE W. S. Murphy		M.D.	
PHYSICIAN'S NAME (Type) W. S. Murphy		615 W. Montgomery Avenue, Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 10/21/61	22c. NAME OF CEMETERY OR CREMATORY Oliver	22d. LOCATION (City, town, or county) (State) Moorefield, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland		24a. REC'D BY REGISTRAR 10/23/61	24b. REGISTRAR'S SIGNATURE Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11567									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>23 Silver Spring</u>				
c. LENGTH OF STAY IN 1b <u>7 yrs</u>					d. STREET ADDRESS <u>104 Croyden et. apt 7</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>104 Croyden et. apt 7</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>THOMAS JOSEPH HANLEY</u>					DATE OF DEATH <u>Oct 17 1961</u>				
5. SEX <u>male</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					B. DATE OF BIRTH <u>10-29-1889</u> 71 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>					11. BIRTHPLACE (State or foreign country) <u>Ireland</u>				
13. FATHER'S NAME <u>Thomas Hanley</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Connell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>577-18-9176</u>				
17. INFORMANT <u>Mary Hanley (wife)</u>					Address <u>Stu 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial</u>					22b. DATE THEREOF <u>10/21/61</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony's Cemetery</u>					22d. LOCATION (City, town, or country) (State) <u>Groton, New York</u>				
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>					24a. REC'D BY REGISTRAR <u>OCT 19 61</u>				
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>									

(M)

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Dr. Richard Potatuford

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Princess Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u>		3. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>4126 Little Creek Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Addie Berman Hanna</u>				4. DATE OF DEATH Month Day Year <u>Oct 1 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/25/82</u>	
9. AGE (in years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Isiah Berman</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Robt. E. Hanna</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY OBSTRUCTION</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>BRONCHO PNEUMONIA</u> (a), stating the underlying cause last, (c) <u>STASIS (BED REST), OBESITY AND SENILITY</u> DUE TO				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Ex HIP</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FALL FROM CHAIR AT HOME</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>9:20 p.m.</u> <u>9/6/61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>KENSINGTON, Md.</u>		20f. (City or town) (County) (State) <u>KENSINGTON, Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/6/61</u> , 19 <u>61</u> , to <u>10/1/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9/29</u> , 19 <u>61</u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE L. RIVAT MD</u>				22d. ADDRESS <u>10620 GEORGIA AVE, S.S., Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Princess Anne Mem. Park Cem</u>		23d. LOCATION (City, town or county) (State) <u>Norfolk Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				ADDRESS <u>5703 Michae</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 4 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No. 11569

11584

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Travilah Rural-Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14178 Travilah Road		d. STREET ADDRESS 14178 Travilah Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDDIE B. HARDING		4. DATE OF DEATH Oct. 19, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/99
9. AGE (In years lost birthday) yrs. 62		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John E. Harding		14. MOTHER'S MAIDEN NAME Anna King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-01-2806	
17. INFORMANT Cora Louise Harding-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5271 Congestive Heart Failure DUE TO Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 months 102yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 Oct 1961 to 19 Oct 1961 , that I last saw the deceased alive on 19 Oct 1961 , and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/19/61			
ACTUAL SIGNATURE W.S. Murphy		M.D.	
PHYSICIAN'S NAME (Type) W.S. Murphy		615 W. Montg. Ave., Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/61	
22c. NAME OF CEMETERY OR CREMATORY Darnestown Church Cem.		22d. LOCATION (City, town, or county) (State) Darnestown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland		24a. REC'D BY REGISTRAR Oct 23 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11585

CERTIFICATE OF DEATH

11570

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beckley	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 304 Rural Acres Drive	
3. NAME OF DECEASED (Type or print) Sandra Kay Harmon		4. DATE OF DEATH Month Day Year October 5 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1945	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tasker G. Harmon		14. MOTHER'S MAIDEN NAME Ethel Douglas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		17. INFORMANT The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease - Ventricular septal defect 754.2 DUE TO (b) Post-Operative closure of ventricular defect Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 36 hours 16 years	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 13, 1961 to October 5, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 5, 1961, and that death occurred at 9:30 PM from the causes and on the date stated above.		22e. SIGNATURE Benson R. Wilcox M.D. 22c. PHYSICIAN'S NAME (Type) Benson R. Wilcox, M.D.	
22b. DATE THEREOF 10/7/61		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL-CREATION-REMOVAL (Specify) removal		23b. NAME OF CEMETERY OR CREMATORY Beckley, W.Va.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.,		25a. REC'D BY REGISTRAR DATE OCT 9 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Frank		25c. DATE OCT 9 '61	

2321

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5/2/01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

11586

11571

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs d. STREET ADDRESS 14511 Colesville Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Glenn Harrison		4. DATE OF DEATH October 28 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1918
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) Illinois (County unknown)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Harrison		14. MOTHER'S MAIDEN NAME Mildred Chapin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 288-14-5945	
17. INFORMATION The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO (b) Cerebellar hemangioblastoma DUE TO (c) 197.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 17 , 19 61 to Oct. 28 , 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 28 , 19 61 , and that death occurred at 7:03 AM from the causes and on the date stated above.			
22a. SIGNATURE Thomas A. Waldmann M.D.		22b. DATE SIGNED 10/28/61	
22c. PHYSICIAN'S NAME (Type) Thomas A. Waldmann, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct. 31, 1961	
23c. NAME OF CEMETERY OR CREMATORY Wash. National		23d. LOCATION (City, town or county) (State) PR. Geo. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. ADDRESS 517-11th St. SE Wash, D.C.		25a. REC'D BY REGISTRAR DATE OCT 31 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

M

11588

Montgomery

Hayland

Montgomery

Richards

14 days

Silver Springs

The Clinical Center, Bethesda 14, Md.

1401 Colasville Road

John

Blum

Howardson

October 23

x

Male

May 26, 1918

13

Telegrams

Unknown

Unknown (County unknown)

John L. Harrison

United States

The Medical Record

588-1-2315 The Clinical Center, Bethesda 14, Maryland

Registration pneumonia

Corneille van der Vliet

x

October 23

Oct. 28

Oct. 28

Oct. 28

Oct. 28

10/28/51

Thomas A. Harrison, M.D.,
Director of Health, Bethesda 14, Md.
The Clinical Center, National
Institute of Health

Wash National
P. O. Box 14

W.W. Harrison Co. 217-11
Oct 28, 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
11587 CERTIFICATE OF DEATH 11572													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Indianapolis</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indianapolis</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oak Haven Convalescent Home</u>						d. STREET ADDRESS <u>5935 Kessler Lane</u>							
3. NAME OF DECEASED (Type or print) <u>Killen F. Hawkins</u>						4. DATE OF DEATH <u>Oct. 1 1961</u>							
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>DIVORCED</u>		8. DATE OF BIRTH <u>Jan 16, 1885</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>15</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>					
13. FATHER'S NAME <u>George M. Heighton</u>						14. MOTHER'S MAIDEN NAME <u>Anna Small</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>535-12-3891</u>							
17. INFORMANT <u>Mrs Peter Ternick, 416 Hillsboro Dr. Silver Sp. Md.</u>						Address <u>Silver Sp. Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>600.0</u> DUE TO <u>Renal insufficiency</u> <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Parkinson's Syndrome</u> DUE TO <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>—</u>												INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St</u>		20f. (City or town) <u>At</u>		(County) <u></u>		(State) <u></u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 28, 1961</u> to <u>Oct 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 28, 1961</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Chas H Volchov</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/1/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>Chas H Volchov</u>						22d. ADDRESS <u>7401 Blair Rd NW Wash D</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>10/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>				23d. LOCATION (City, town or county) <u>Prince George's County, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumfrey</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>						25a. REC'D BY REGISTRAR <u>OCT 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

732

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11588

11573

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>46</u>		d. STREET ADDRESS <u>8711 Grant Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>R.</u> Last <u>Hayden</u>		4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>19 61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 26, 1896</u>
9. AGE (in years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance adjuster</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas.</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fitzgerald</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>navy 1st war</u>		16. SOCIAL SECURITY NO. <u>518-10-9325</u>	
17. INFORMANT <u>Rose Hayden</u>		Address <u>Above (w. f.)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <u>Pulmonary infarction, lt. lobe</u> <u>Pulmonary thrombosis, lt</u> <u>Oblique Coronary insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Polyneuritis (nutritional?)</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Allen J. O'Neill</u>		22b. DATE SIGNED <u>10/5/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill MD</u>		22d. ADDRESS <u>8601 Old Georgetown Rd Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/5/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l.</u>		23d. LOCATION (City, town or county) (State) <u>Ft. Myer, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 4 '61</u>	
ADDRESS <u>517-14th St. S.E. Washington</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

M

1882

1882

1882

TO SPIRITUAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11589

CERTIFICATE OF DEATH

Item 23a Film G298 10/30/61

11574

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 12 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk d. STREET ADDRESS 5109 East Princess Anne Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph Leonard Heath		4. DATE OF DEATH October 21, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 19, 1906
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 21 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (County & State, or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eric N. Heath		14. MOTHER'S MAIDEN NAME Tilda Abeldson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1925-1955		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 421-1 (b) Calcific aortic valvulitis with aortic stenosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 9, 1961 to October 21, 1961 , that (I) (we) last saw the deceased alive on October 21, 1961 , and that death occurred 12:30AM from the causes and on the date stated above.			
22a. SIGNATURE Kenneth L. Melman M.D.		22b. DATE 10/21/61	
22c. PHYSICIAN'S NAME (Type) KENNETH L. MELMAN, M.D.		22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF Oct. 25, 61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert J. Murphy		25a. REC'D BY REGISTRAR OCT 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

(M)

11580

Management

Bellevue

12 days

The Medical Center, Bethesda II, Md. 20814

Leath

Leath

Leath

Male

White

December 19, 1905

Navy

U.S. Navy

Minnesota

Miss Abelson

Eric M. Heath

The Medical Center

The Clinical Center, Bethesda II, Maryland

None

1922-1925

Yes

Cardiac arrest

Calcific aortic valvulitis with aortic stenosis

October 2, 1930
12:30AM

October 21, 1930

10/21/30

The Clinical Center, Bethesda II, Maryland
Institute of Health, Bethesda II, Maryland

RENNETT L. MURPHY, M.D.

Washington, D.C.
The Clinical Center, Bethesda II, Maryland

CERTIFICATE OF DEATH

Reg. Dist. No. 11575

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 733 Sligo Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Catherine Middle Bernadette Last Hellmuth				4. DATE OF DEATH Month October Day 6 Year 1961			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1885	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXX Clerk-Retired				10b. KIND OF BUSINESS OR INDUSTRY Dept. of Interior		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Langley			
14. MOTHER'S MAIDEN NAME Catherine O'Brien				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				INFORMANT Miss Catherine I. Hellmuth Address 733 Sligo Avenue, Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 3-4YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF COLON WITH METASTASES							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/26 , 19 61 , to 10/6 , 19 61 , that I last saw the deceased alive on 10/6 , 19 61 , and that death occurred at 11:53 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7720 WISCONSIN AVE, BETHESDA MD DATE SIGNED 1961 ACTUAL SIGNATURE John H. Tuohy PHYSICIAN'S NAME (Type) John H. Tuohy 7720 Wisconsin Avenue, Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/10/61			
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				22d. LOCATION (City, town, or county) (State) Washington D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Pumphrey Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Md.				24a. REC'D BY REGISTRAR DATE OCT 10 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



2

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11591

11576

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resmor Sanitarium		e. STREET ADDRESS 3912 Leland Street	
3. NAME OF DECEASED (Type or print) First Paul Middle Renno Last Heyl		4. DATE OF DEATH Month October Day 22 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1872
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 3 Days 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physicist		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry R. Heyl		14. MOTHER'S MAIDEN NAME Mary R. Knauff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Roger W. Jones-Daughter-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 410X } DUE TO Conditions, if any, which gave rise to immediate cause (b) Mitral insufficiency (c) 410X } DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 10 da 5-10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 12, 1956 to Oct 22, 1961 that (I) (we) last saw the deceased alive on Oct 22, 1961 , and that death occurred at 6 PM , from the causes and on the date stated above.			
22a. SIGNATURE Katharine A. Chapman M.D.		22b. DATE SIGNED October 22, 1961	
22c. PHYSICIAN'S NAME (Type) Katharine A. Chapman		22d. ADDRESS 3924 Baltimore Rd. Kensington Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 10/23/61	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City, town or county) (State) Suitland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 24 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

20

19



Robert A. Emphrey, Bethesda, Maryland

1
FOR STATE
HEALTH DEPT.

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11592 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11577

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in 1b 17 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 4101 Manor Rd.,	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Milton Middle Hicks Last Hicks				4. DATE OF DEATH Month Oct. Day 10 Year 19 61			
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/97	9. AGE (in years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 64 Days 64	IF UNDER 24 HRS. Hours 64 Min. 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James C. Hicks			14. MOTHER'S MAIDEN NAME Anna Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-16-7254		17. INFORMANT Sylvester Pitman		Address same as above	
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO (b) Ischemic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 16 hours Unknown	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Bluschaw M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-10-61	
EXAMINER'S NAME (Type) FRANK J. Bluschaw				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/61		22c. NAME OF CEMETERY OR CREMATORY Hope Hill.,		22d. LOCATION (City, town, or country) (State) Buckeystown, Md.	
23. FUNERAL DIRECTOR Robert L. Swallen ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR OCT 17 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

11303

(M)

(T)

Rockville, Md.
Home Hill

10/1/51

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11593						11578					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			Montgomery			a. STATE			Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Rockville			b. COUNTY			Montgomery		
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
700 Grandin Ave.						700 Grandin Ave.					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
FLORENCE HOLLAND						Oct. 3, 1961					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 26, 1870		91 yrs.		Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Housewife				Maryland		U. S.					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
George Dorsey Clark						Alice Linthicum					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.					
No						None					
17. INFORMANT						Address					
Sister						Same as Item 2.					
Mrs. F. J. LeMoine											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
422.1 DUE TO acute dilatation of heart											
Conditions, if any, which gave rise to immediate cause (b) chronic myocarditis										1958	
(c) cancer right femur										1959	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED	
Hour a.m. p.m. 19										While Not While at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1958, to October 3, 1961, that (I) (we) last saw the deceased alive on Oct 2, 1961, and that death occurred at 4:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE										22b. DATE SIGNED	
Gilbert V. Hartley										Oct. 4, 1961	
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS	
Gilbert V. Hartley										103 Forest Ave., Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF	
Burial										10/6/61	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town or county) (State)	
Rockville Cemetery										Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE										25a. REC'D BY REGISTRAR	
Robert A. Pumphrey, Bethesda, Maryland										DATE OCT 13 '61	
										25b. REGISTRAR'S SIGNATURE	
										Arthur S. Kraus	

11303

(M)

700 Franklin Ave.

700 Franklin Ave.

W. J. H. H.

HOLLAND

1000 10th St.

1000 10th St.

1000 10th St.

1000 10th St.

1000 10th St.

1000 10th St.

1000 10th St.

1000 10th St.

1000 10th St.

1000 10th St.

1000 10th St.

Clifford V. Hartley

1000 10th St.

Bureau

10/2/51

Rockville Cemetery

Rockville, Maryland

Robert A. Humphrey, Bethesda, Maryland

40256

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11595

11580

1. PLACE OF DEATH COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hosp.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 2117 Beechwood Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) George		4. DATE OF DEATH Month 10 Day 7 Year 1961		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-23-10		9. AGE (In years last birthday) yrs. 51		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Branch Chief, Army Map Service				10b. KIND OF BUSINESS OR INDUSTRY West Va.				11. BIRTHPLACE (County & State, or foreign country) USA.				12. CITIZEN OF WHAT COUNTRY? USA.											
13. FATHER'S NAME Walter Lee Hopkins				14. MOTHER'S MAIDEN NAME Carry Detamore.				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Old Record.				17. INFORMANT Old Record.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Cardiac Metastasis from Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Carcinoma Right Lung DUE TO (c) Pathologic Fracture Right Humerus												INTERVAL BETWEEN ONSET AND DEATH 5 minutes 3 months 6+ months											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pathologic Fracture Right Humerus												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (He she) attended the deceased from June , 19 61 , to October 7 , 19 61 , that (I) (we) last saw the deceased alive on Oct 7 , 19 61 , and that death occurred at 1007 P.M., from the causes and on the date stated above.																							
22a. SIGNATURE Marvin L. Kolkin								22b. DATE SIGNED Oct. 7, 1961				22c. PHYSICIAN'S NAME (Type) MARVIN L. KOLKIN M.D.				22d. ADDRESS 1015 SPRING STREET, S.S., MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 10/10/61				23c. NAME OF CEMETERY OR CREMATORY Greenwich Presbyterian Cemetery				23d. LOCATION (City, town or county) (State) Greenwich, Va.											
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Himes Co.								ADDRESS 2901-14th St. N.W.				DATE OCT 11 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Knapp							

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1

Standard and Record Co.

1222

Washington

Takoma Park

Washington Government + Hop 217 Reservoir Rd

Grade X water Hopkins

2-3-10 21

March 1911. Army Map Service (see p. 12A)

Water Lee Hopkins

See Record

Washington

D. O. A. Water 116

X

10 7 61

The S. H. Morse Co
Washington D. C.
2401-14th St N.W.
Dist. of Columbia

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11596		Item 9 Film G297		10/10/61 1wk		11581	
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood R.F.D.#1		c. LENGTH OF STAY IN 1b 8 Months		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammons Nursing Home		d. STREET ADDRESS 2218 University Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clara Middle C. Last Horad		4. DATE OF DEATH Month October Day 2 Year 1961					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 20, 1881	
9. AGE (In years lost birthday) yrs. 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William F. Horad		14. MOTHER'S MAIDEN NAME Belle Williams		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. item 2	
17. INFORMANT Romeo Horad Sr.		Address item 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Hypertensive Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH 5 years (P) 5 years +					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1955 to Oct 2, 1961 (that (I) (we) last saw the deceased alive on 9/30, 1961 , and that death occurred at 5:4 M. from the causes and on the date stated above.		22a. SIGNATURE Calvin B. LeCompte		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/5/61	
22c. PHYSICIAN'S NAME (Type) Calvin B. LeCompte		22d. ADDRESS 61 R St - N E Wash, DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/61		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park..		23d. LOCATION (City, town, or county) (State) Prince Geo. County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE OCT 6 '61		25b. REGISTRAR'S SIGNATURE William S. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11597											
11582											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. LENGTH OF STAY IN 1b 82 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.						d. STREET ADDRESS 400 Gaithersburg Street					
3. NAME OF DECEASED (Type or print) Bertha						4. DATE OF DEATH Month October Day 23 Year 19 61					
5. SEX Female						6. COLOR OR RACE White					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH January 13, 1893					
9. AGE (In years last birthday) yrs. 68						10. IF UNDER 1 YEAR Months 07 Days 1 Year 19 61					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY None					
11. BIRTHPLACE (County & State, or foreign country) Denmark						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Nels Swanson						14. MOTHER'S MAIDEN NAME Katherine Johnson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No						16. SOCIAL SECURITY NO. None					
17. INFORMANT The Medical Record						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that 1 (this hospital) attended the deceased from August 2, 19 61 to October 23, 19 61 that 1 (we) last saw the deceased alive on October 23, 19 61 , and that death occurred at 7:20 A.M. from the causes and on the date stated above.											
22a. SIGNATURE James D. Prokop						22b. DATE SIGNED October 23, 19 61					
22c. PHYSICIAN'S NAME (Type) James D. Prokop						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						23b. DATE THEREOF 10/25/61					
23c. NAME OF CEMETERY OR CREMATORY Prospect Cemetery						23d. LOCATION (City, town or county) (State) Portage, Penna.					
24. FUNERAL DIRECTOR'S SIGNATURE Randolph Leckung						25a. REC'D BY REGISTRAR OCT 24 '61					
25b. REGISTRAR'S SIGNATURE Caroline L. Kenna											

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11598 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>						c. LENGTH OF STAY IN 1b <u>2 yrs</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>422 McArthur Drive</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Virginia Blanch Howell</u>						4. DATE OF DEATH <u>Dec 27 1961</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>Sept 12 1888</u>					
9. AGE (In years last birthday) <u>73</u> yrs.						10. IF UNDER 1 YEAR Months Days					
11. IF UNDER 24 HRS. Hours Min.						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>					
11. BIRTHPLACE (State or foreign country) <u>md</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>Unknown</u>					
17. INFORMANT <u>Katherine Howell</u>						Address <u>4550 Conn. Ave N.W. Wash. D.C.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Cornary occlusion</u> DUE TO (b) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>History of previous heart disease</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED <u>10-27-61</u>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.											
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>10/31/61</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>											
22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>											
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>											
ADDRESS											
24a. REC'D BY REGISTRAR <u>OCT 31 '61</u>											
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>											

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TABLE 1

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

11600 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11585

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			d. STREET ADDRESS <u>7400 Flower Ave</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Holly</u> Middle <u>Sharon</u> Last <u>Huffman</u>			4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1961</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>December 13, 1946</u>		9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		
11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Thomas Dayton Huffman</u>			14. MOTHER'S MAIDEN NAME <u>Emma Augusta Haas</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)			16. SOCIAL SECURITY NO. <u>—</u>		
17. INFORMANT <u>Records, Family</u>			Address <u>—</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTERNAL HYDROCEPHALUS, MARKEDLY SEVERE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>344.1</u> DUE TO (c) <u>—</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL PALSY</u> for life					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-27-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 30, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
22d. LOCATION (City, town, or country) <u>Prince George's County, Md.</u>		22e. REC'D BY REGISTRAR <u>Arthur Walters</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>	
23. FUNERAL DIRECTOR <u>Arthur Walters</u>		ADDRESS <u>254 Carroll St. NW D.C.</u>		DATE <u>OCT 30 '61</u>	

MEDICAL CERTIFICATION

11508

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Student

Thomas Dwyer Hoffman

Records, Family

Emma Augusta Hays

Ex-Kennel Park, Maryland N. C.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11601

11586

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON, SILVER SPRING c. LENGTH OF STAY IN 1b 50 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2015 SHOREFIELD ROAD				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND f. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 2015 SHOREFIELD ROAD • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRY CLEVELAND HULL			4. DATE OF DEATH Month OCTOBER Day 7 Year 19 61				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 21, 1885		9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN (retired)		10b. KIND OF BUSINESS OR INDUSTRY GOV'T. MONTGOMERY COUNTY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME CHARLES M. HULL				
14. MOTHER'S MAIDEN NAME MARGARET ROBERTS			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO				
16. SOCIAL SECURITY NO. 579-20-0427			17. INFORMANT HARRY B. HULL, 4415 ASPEN HILL RD., ROCKVILLE, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis (b) arteriosclerosis (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Silver Spring Mount 20f. (City or town) (County) (State) MD							
21. I certify that (I) (this hospital) attended the deceased from Jan 1961 , 19____, to Oct 7 , 19 61 , that (I) (we) last saw the deceased alive on Oct 7 , 19 61 , and that death occurred at 10 AM , from the causes and on the date stated above.							
22a. SIGNATURE Patrick Jameson M.D. 22c. PHYSICIAN'S NAME (Type) PATRICK JAMESON			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 12,020 GEORGIA AVE., SILVER SPRING, MD. 22b. DATE SIGNED Oct. 9, 1961				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 10, 1961		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY			
23d. LOCATION (City, town or county) (State) PRINCE GEORGE'S COUNTY, MD.		24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc., SILVER SPRING, MD.					
25a. REC'D BY REGISTRAR DATE OCT 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

11001

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

11602

11587

1. PLACE OF DEATH e. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA d. STREET ADDRESS 6005 WALTON RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) ELLA CHAPPELL HUNDLEY First Middle Last				4. DATE OF DEATH OCT. 16 19 61 Month Day Year											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/28/91		9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles B. Chappell				14. MOTHER'S MAIDEN NAME Emma L. Slater				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None				17. INFORMANT Daughter Mrs. Blanche Brust			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Bleeding Esophageal VARICES 581.0 DUE TO Cirrhosis, Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO												INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (the hospital) attended the deceased from July 27, 1950 to Oct. 16, 1961 , that (I) (we) saw the deceased alive on Oct. 16, 1961 , and that death occurred at 12:15 PM , from the causes and on the date stated above.															
22a. SIGNATURE Robert G. Angle						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/16/61							
22c. PHYSICIAN'S NAME (Type) Robert G. Angle						22d. ADDRESS 5009 DelRay Ave. Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 10/20/61				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Mem. Park				23d. LOCATION (City, town or county) (State) Louisville, Kentucky					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland						25a. REC'D BY REGISTRAR OCT 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

11008

(M)

(1)

None

Robert A. Phillips

3009 Delmar Ave., Baltimore, Md.

But-Trenton 10/20/51 East Haven Mem. Park Louisville, Kentucky

Robert A. Phillips, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11603

CERTIFICATE OF DEATH

11588

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY White Plains c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 20 North Broadway d. STREET ADDRESS 69X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Gunther Waldemar Hunter			4. DATE OF DEATH Month October Day 14 Year 19 61		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 27, 1903		9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months 5 Days 10 Hours 15 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) X-ray Salesman		10b. KIND OF BUSINESS OR INDUSTRY X-Ray		11. BIRTHPLACE (County & State, or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry Hunter Herman Hunter			
14. MOTHER'S MAIDEN NAME Else Friedlander		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 087-01-6056		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma with carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Atelectasis of left lung DUE TO (c) Duodenal ulcer					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) 20h. (State)	
21. I certify that (X) (this hospital) attended the deceased from October 2, 1961 to October 14, 1961 that (X) (we) last saw the deceased alive on October 14, 1961 and that death occurred 8:45AM from the causes and on the date stated above.					
22a. SIGNATURE Robert H. Levin		22b. DATE SIGNED 10/14/61		22c. PHYSICIAN'S NAME (Type) ROBERT H. LEVIN, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			
23b. DATE THEREOF Oct. 15, 1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION (City, town or county) Prince Georges Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey		25a. REC'D BY REGISTRAR OCT 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11603

(M)

Montgomery

New York

Bathesda

14 12 days

White Plains

The Clinical Center, Bethesda 11, Md.

20 North Broadway

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Walton

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June 27, 1903

88

Kary Solomon

X-Ray

England

U.S.A.

Harry Kantor

Electrocardiogram

The Medical Record

001-01-006 The Clinical Center, Bethesda 11, Maryland

(I)

Prothogenic carcinoma with carcinomatosis

Atelocystic of left lung

Prothogenic ulcer

x

x

October 11, 61

8:45AM

October 2

October 11

x

10/11/61

The Clinical Center, National Institutes of Health, Bethesda 11, Md.

ROBERT H. LEVINE, M.D.

CERTIFICATE OF DEATH

Reg. Dist. No.

11589

11604

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Hurd Last Hurd		4. DATE OF DEATH Month Oct Day 2 Year 1961	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 2 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-lady		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Young		14. MOTHER'S MAIDEN NAME Mary S. Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr George E. Shackelford (Same as Item #2)	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myocardial infarction DUE TO (c) Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Diabetes INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 12 1960 , to Oct 2, 1961 , that I last saw the deceased alive on Sept 25, 1961 , and that death occurred at 4:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1219 Seminary Rd Silver Spring, Md DATE SIGNED 10-26-61			
ACTUAL SIGNATURE [Signature]		PHYSICIAN'S NAME (Type) [Signature]	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/3/61	
22c. NAME OF CEMETERY OR CREMATORY Mt Zion Cem.		22d. LOCATION (City, town, or county) (State) Silver Spring, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Browder		24. REC'D BY REGISTRAR Oct 10 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11604



NO. 1

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1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11605 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>104 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium & Hospital</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>XXXXXX</i> b. COUNTY <i>ARLINGTON, VIRGINIA</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Washington, Virginia</i> d. STREET ADDRESS <i>111 Arlington Blvd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Claude Emerson Huson</i>				4. DATE OF DEATH <i>10-9-1961</i>				5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Mattos Inc.</i>				11. BIRTHPLACE (State or foreign country) <i>N. J.</i>			
13. FATHER'S NAME <i>Arthur B. Huson</i>				14. MOTHER'S MAIDEN NAME <i>Minnie Gordon</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>XXXX-XX-XXXX</i>				17. INFORMATION Address <i>Washington Sanitarium & Hosp. Rec.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brain lacerations and contusions</i> DUE TO (b) <i>Fracture of the skull</i> DUE TO (c) <i>A fall</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 months</i> <i>3 1/2 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Reported fall on floor at home</i>							
20c. TIME OF INJURY Month, Day, Year Hour <i>7</i> p.m. <i>6-27 1961</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>			
				20f. (City or town) <i>Washington</i> (County) <i>D.C.</i> (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Frank J. Broschert</i>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>10-9-61</i>			
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>				22b. DATE THEREOF <i>10/11/61</i>				22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>			
				22d. LOCATION (City, town, or country) <i>PP, Geo. Co., Md.</i>							
23. FUNERAL DIRECTOR <i>Wm. Chambers</i>				ADDRESS <i>1400 Chapin St NW</i>				24a. REC'D BY REGISTRAR <i>OCT 13 '61</i>			
								24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			

MEDICAL CERTIFICATION

11605

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Loudon c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Paeonian Springs d. STREET ADDRESS Box 24 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JERRY LYNN JAMES		4. DATE OF DEATH Month October Day 13 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 6, 1957
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William James		14. MOTHER'S MAIDEN NAME Eva Mae Helbert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rhabdomyosarcoma - metastasis to brain, lungs, kidney and pancreas DUE TO (b) Bronchopneumonia DUE TO (c) Gastrointestinal hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 16 months 2 weeks 2 days	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 22, 1961 to October 13, 1961 , that <input type="checkbox"/> (we) last saw the deceased alive on Oct. 13, 1961 , and that death occurred at 9:13AM from the causes and on the date stated above.		22a. SIGNATURE J. David Heywood, M.D. 22b. DATE SIGNED 10/13/61	
22c. PHYSICIAN'S NAME (Type) J. David Heywood, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/15/61	
23c. NAME OF CEMETERY OR CREMATORY Bethel Church		23d. LOCATION (City, town or county) (State) Leesburg, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		25a. REC'D BY REGISTRAR Oct 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

11003

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Montgomery

Rebecca

The Clinical Center

JERRY

LYNN

JAMES

October

Box 21

21 days

Paediatric Springs

London

Male

White

x

November 6, 1957

3

None

Virginia

USA

William James

Mrs. Mae Holbert

The Medical Record

The Clinical Center, Bethesda 14, Maryland

None

10

Encephalopathy - metastatic to brain, lungs, kidneys and pancreas

Encephalopathy

2 weeks

Gastrointestinal hemorrhage

2 days

x

x

Oct. 13, 61

September 22, 61
9:13AM

October 13, 61

x

J. David Heywood, M.D.

Institute of Health, Bethesda 14, Md.
The Clinical Center, National

10/13/61

x

W.W. Saunders Co. 10/12/61
Burial 10/12/61
Bertel Church

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11607

CERTIFICATE OF DEATH

11592

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 609 Deerfield Avenue S.S. Md.				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 609 Deerfield Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) IDA First EVA Middle JOHNSON Last			4. DATE OF DEATH Month October Day 6 Year 19 61				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 3/15/1877		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 0 Days 0			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (County & State, or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown Tiittinen			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Herbert F. Hathaway 609 Deerfield Avenue Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 450.0 DUE TO Cardiac Deletation Acute Pneumonia Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 0 p.m. 0		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 5 , 19 61 , to Oct 6 , 19 61 , that (I) (we) last saw the deceased alive on Oct 5 , 19 61 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE W B Wardrop M.D.				22b. DATE SIGNED 10/6/61			
22c. PHYSICIAN'S NAME (Type) W. B. Wardrop, M. D.				22d. ADDRESS 800 Pershing Drive, Suite 205, S. S., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/9/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			
23d. LOCATION (City, town or county) Prince George Co Md.		24. REGISTRAR'S SIGNATURE Raymond H. Zisk					
25a. REC'D BY REGISTRAR OCT 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MONTGOMERY
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MONTGOMERY
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		d. STREET ADDRESS <u>607 Alden Street</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edgar</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-13-1885</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>13</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Marion Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Isaac Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Nicholson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-07-6563</u>	
17. INFORMANT <u>Worthy E. Johnson</u>		Address <u>607 Alden St., Gaithersburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, High Arterial Tension</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April - 1961</u> to <u>Oct-26-1961</u> , that (I) (we) last saw the deceased alive on <u>Oct-26-1961</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William C. Miller, M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>		22d. ADDRESS <u>7 Brooks Ave., Gaithersburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>10-22-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest Gortner</u>		ADDRESS <u>Gaithersburg, Md.</u>	
25a. RECORD REGISTRATION DATE <u>OCT 30 1961</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thayer</u>	

1003

CERTIFICATE OF DEATH

Marriage

Marriage

Marriage

4 years

Marriage

1874-1875

at home

Oct 22 - 61

James Johnson

James

Wife

Aug 13-1875

from marriage

Marriage

James Johnson

1875-1876

Acute

Marriage

Aug 13 - 61

Oct 22 - 61

William B. Miller, M.D.

William C. Miller

Marriage

Marriage

Marriage

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11609

11594

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colesville</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marlee Nursing Home</u>				d. STREET ADDRESS <u>18438 Piney Branch Court</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MINNIE</u> First <u>B</u> Middle <u>JOHNSON</u> Last				4. DATE OF DEATH <u>OCT</u> Month <u>19</u> Day <u>1961</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 30, 1873</u>	
9. AGE (In years lost birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswoman (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Sales</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>							
13. FATHER'S NAME <u>Jefferson G. Perren</u>				14. MOTHER'S MAIDEN NAME <u>Jennie H. Bokes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>100-1-10000</u>			
17. INFORMANT <u>Dorothy F. Decker, (same as #2)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Senile Arteriosclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 years</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town). (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> 19 <u>56</u> to <u>19 Oct</u> 19 <u>61</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>12 Oct</u> 19 <u>61</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>M B Queen</u>				22b. DATE SIGNED <u>19 Oct 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>M B QUEEN</u>				22d. ADDRESS <u>7112 Yellow Doe Takoma Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 23, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Neesburg, West Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				25a. REC'D BY REGISTRAR <u>254 Carroll St. N.W. Wash. D.C.</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>				DATE <u>OCT 23 '61</u>			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11610

Item Id, Film G297 10/11/61 iwk

11595

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN lb 3 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Private home, Crocus Drive				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson d. STREET ADDRESS ----- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Reginald Bernard Jones				4. DATE OF DEATH Month 10 Day 1 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1877	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 1 YEAR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural mail carrier				10b. KIND OF BUSINESS OR INDUSTRY Gov. mail carrier		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Henry Jones				14. MOTHER'S MAIDEN NAME Ella Shaw			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. C. Robert Jones			
17. INFORMANT Dickerson, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (b) GENERALIZED METASTASIS (c) BROCHIOGENIC CARCINOMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE							
INTERVAL BETWEEN ONSET AND DEATH ONE HOUR ONE YEAR ONE YEAR							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT. 20, 1961 to OCT 2, 1961 , that (I) was last saw the deceased alive on 29 SEPT. 1961 , and that death occurred at 4 PM , from the causes and on the date stated above.							
22a. SIGNATURE Gordon S. Rosenberger M.D.				22b. DATE SIGNED 1 Oct. 1961			
22c. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger				22d. ADDRESS 310 W. MONTGOMERY DR. ROCKVILLE MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/61		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town or county) (State) Barnesville Md.	
24 FUNERAL DIRECTOR'S SIGNATURE William B. Helton, Barnesville, MD				25a. REC'D BY REGISTRAR OCT 5 '61		25b. REGISTRAR'S SIGNATURE Gordon S. Rosenberger	

MEDICAL CERTIFICATION

TO SPIRITUAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

1877

1877

Montgomery

Married

Montgomery

Rockville

3 weeks

Dickerson

Married

Bernard

Jones

10

1

61

Male

White

X

June 18, 1877

64

Grand anti-slavery - Gov. anti-slavery

Married

Married

U.S.

Henry Jones

Ellis Shaw

No

C. Robert Jones

Dickerson, Md.

No.

Bayonneville

St. Mary's

10/3/01

Enroll

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11611

11597

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Oakhaven - 517 Albany Ave.		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY (D.C.) Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 5530 Chillum Pl. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Isadore First Middle Last 4. DATE OF DEATH 10 20 1961 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March 18 - 1888 9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (County & State, or foreign country) Kiev, Russia 12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Bernard Katzman 14. MOTHER'S MARDEN NAME Ida	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 219-32-0357 17. INFORMANT Atch Rosenheim (daughter) Silver Spring Md. Address 816 Malta Lane		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO (b) ARTERIOSCLEROTIC DISEASE DUE TO (c) CARDIO-VASCULAR REAL DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① GOUT ② DIABETES MELLITUS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1949 to 10-20-61 , that (I) (we) last saw the deceased alive on 10-19-1961 , and that death occurred at 12:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Samuel A. Hillman 22c. PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN		22b. DATE SIGNED 10-20-61 22d. ADDRESS 8829 - FLOWER AVE. SILVER SPRING	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 10/21/61 23c. NAME OF CEMETERY OR CREMATORY OHEV SHOLOM Cem. 23d. LOCATION (City, town or county) (State) Wash. DC		24. FUNERAL DIRECTOR'S SIGNATURE Solberg Funeral Home ADDRESS 4217-9th Ave 25a. REC'D BY REGISTRAR OCT 23 '61 25b. REGISTRAR'S SIGNATURE John P. Hume	

Montgomery
Tarkenton Park

Cushman - 217 Highland Ave
2230 William St. N.E.

Isador - Katzman

Male White x March 18-1888 23

Tailor

Bernard Katzman

Ida

Kiev, Russia

United States

816 West Ave.

2193-2211th Rosenheim (dolph) 21st St. N.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11612					11598						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY				
Montgomery		MARYLAND			West Virginia		✓				
Bethesda (Rural)		2 days			Sutton		85X-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
U. S. Naval Hospital					Herold Route Box 81						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
Irene Pearl					Keener		October 1		1961		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR	
Female		Caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		May 15, 1961		4		17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Infant						France		USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
George Dewey Keener					Emma Jean Rose						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					17. INFORMANT Address						
No					(Mother) Emma Jean Keener, Same as #2 above						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital Heart Disease</i>											
754.5 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)											
										4 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<i>Post-operative block procedure</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that the (this hospital) attended the deceased from <i>Sept. 29</i> , 1961, to <i>Oct. 1</i> , 1961, that to (we) last saw the deceased alive on <i>Oct. 1</i> , 1961, and that death occurred at <i>9:30 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>A. T. Thorp Jr.</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2 October 1961				
22c. PHYSICIAN'S NAME (Type) A. T. THORP, JR. LT MC USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
Burial-Shipment			6 Oct 1961		Keener Family Cemetery		Sutton, W. Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<i>Robert A. Pumphrey</i> Robert A. PUMPHREY Funeral Home, Bethesda, Md.					DATE OCT 9 '61		<i>Arthur S. Hines</i>				

9VVVVVVVVVV

11013

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11013

11013

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11613

11599

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>10, 515 Cascade Place</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LeDeau Gardens Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Montgomery</u> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> h. STREET ADDRESS <u>10, 515 Cascade Place</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Mildred</u> First Middle Last				4. DATE OF DEATH <u>October 31, 1961</u> Month Day Year											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 30, 1881</u>		9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown Humphrey</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT Address <u>Mrs. Cavet C. Snyder 10, 515 Cascade Place Silver Spring, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/27/61</u> , 19 <u>61</u> , to <u>10/21/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/21/1961</u> , and that death occurred at <u>10/21/61</u> , M, from the causes and on the date stated above.															
22a. SIGNATURE <u>John David Herman</u> M.D.								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov 1, 1961</u>					
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 11/6/61</u>				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Spearfish, South Dakota</u>			
24. FUNERAL HOME <u>Arner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>NOV 3 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Chronic bronchitis
Chestnut Street
Philadelphia
Pa.

Johnston House

Philadelphia, Pa.
Chestnut Street
Johnston House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington San. & Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs d. STREET ADDRESS 8613 Piney Branch Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond First Middle Last 4. DATE OF DEATH 10 15 1961 Month Day Year		5. SEX Male 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 11-28-86 9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - U.S. Govt. 10b. KIND OF BUSINESS OR INDUSTRY D. C. 11. BIRTHPLACE (County & State, or foreign country) American 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Kyle, John T. 14. MOTHER'S MAIDEN NAME Hellen Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 579-16-0388 17. INFORMANT Pt. chart. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 500x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute Bronchitis DUE TO (c) Bacterial Infection: Pseudomonas Aer. and E. Coli PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Emphysema Constrictive Heart Failure 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from October 14, 1961 , to October 15, 1961 , that (I) (we) last saw the deceased alive on October 15, 1961 , and that death occurred at 12:25 PM , from the causes and on the date stated above. 22a. SIGNATURE Stuart L. Nelson M.D. 22b. DATE SIGNED 10/16/61 22c. PHYSICIAN'S NAME (Type) STUART L. NELSON 22d. ADDRESS 7600 CARROLL AVE. TAKOMA PARK, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 10-18-61 23c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY WASHINGTON D. C. 23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS 3821-14th St. NW Wash. D.C. 25a. REC'D BY REGISTRAR ACT 18 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11615

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PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlanta Park</u> c. LENGTH OF STAY IN 1b <u>1 Hr. 25 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>616 SILVER SPRING AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Theodore (None) Lapkoff</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-20-04</u> 9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>4</u> Year <u>1961</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal Mechanic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Body + Fender mfr</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Meyer - Lapkoff</u> 14. MOTHER'S MAIDEN NAME <u>Sofie</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>577-07-1995</u> 17. INFORMANT <u>wife Mrs Bertha Lapkoff</u> Address <u>?</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> , 19 <u>61</u> , to <u>10/14</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> , 19 <u>61</u> , and that death occurred at <u>1:10 P.M.</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>John A. Reisinger</u> M.D. 22b. DATE SIGNED <u>10/14/61</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN A. REISINGER</u> 22d. ADDRESS <u>901-20th N.W. WASH. D.C.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10/6/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>B'NAI ISRAEL Cem</u> 23d. LOCATION (City, town or county) <u>OXON HILL, MD.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Isidore J. Tenebrun</u> ADDRESS <u>4217-9th St NW</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. F. Booschar + Contacted + gave consent for burial. Dr. Reisinger to sign death certificate.

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~~The above (Name) is bankrupt~~

TO SPECIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11616 CERTIFICATE OF DEATH 11602											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4405 East-West Highway, Apt. 602						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4405 East-West Highway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ESPER SIGNIUS LARSEN, III			4. DATE OF DEATH Month Oct. Day 6, Year 19 61			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Oct. 10, 1912			9. AGE (In years last birthday) 48 yrs.			IF UNDER 1 YEAR Months 11 Days 26		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Geologist						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) California		
13. FATHER'S NAME Esper Signius Larsen, Jr.						14. MOTHER'S MAIDEN NAME Eva Audrey Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO.			17. INFORMANT Wife Marjorie A. Larsen Address Same as Item 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO (b) Coronary Thrombosis + Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypertensive Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH Minutes Unknown 13 +											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Paraplegia, 37 yrs, due to injury in childhood											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that, (I) (the hospital) attended the deceased from May 1950 to present , 19 61 , that (I) (we) last saw the deceased alive on 10/4 , 19 61 , and that death occurred at 7:57 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Francis J. Murray M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10/6/61		
22c. PHYSICIAN'S NAME (Type) FRANCIS J. MURRAY MD						22d. ADDRESS 2111 Bancroft Pl NW Wash DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 10-7-61			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION (City, town or county) (State) Prince George Co., Md.		
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY						ADDRESS Bethesda, Md.			25a. REC'D BY REGISTRAR Oct 13 61 DATE		
						25b. REGISTRAR'S SIGNATURE William E. Evans					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

B.D.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
11617													
Items 1 & 2 Film 299 11/3/61 iwk													
1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2601 Bel Pre Rd. Bel Pre Nursing Home				c. LENGTH OF STAY IN lb 26 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Silver Spring, Md.				e. STATE Maryland				f. COUNTY Montgomery					
g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 434109 Knowles Ave., Kensington				h. STREET ADDRESS				i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Alick				First Middle Last Leibowitz				4. DATE OF DEATH 10 26 19 61					
5. SEX Male		6. COLOR OR RACE Hebrew		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser				10b. KIND OF BUSINESS OR INDUSTRY Clothing				11. BIRTHPLACE (County & State, or foreign country) Poland				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -				16. SOCIAL SECURITY NO. 346-01-2346	
17. INFORMANT Mrs. Roberta Leib				Address 6306 Crathie Lane, D.C.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO (b) Carcinomatosis DUE TO (c) Carcinoma of right kidney				INTERVAL BETWEEN ONSET AND DEATH June, 1961	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from June 1961, to Oct 1961, that (I) (we) last saw the deceased alive on 10/15 1961, and that death occurred at 2:15 PM, from the causes and on the date stated above.													
22a. SIGNATURE Maurice Franks				M.D. 22c. PHYSICIAN'S NAME (Type) Maurice Franks, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22d. ADDRESS 901 20th St NW, Wash 6, D.C.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct 27, 1961		23c. NAME OF CEMETERY OR CREMATORY Geo. Washington Cem.		23d. LOCATION (City, town or county) Hyattsville, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Shelley Funeral Home				ADDRESS 4217 9th St NW				25a. REC'D BY REGISTRAR DATE OCT 30 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Continuation of report of
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TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11618

CERTIFICATE OF DEATH

11604

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b MARILEA NURSING HOME		d. STREET ADDRESS 4003 Blackpool Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 14,511 Colesville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carrie Henrietta Leins		4. DATE OF DEATH October 3, 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH April 17, 1881		9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN Henry W. Sievers		14. MOTHER'S MAIDEN NAME UNKNOWN Elizabeth Trusheim			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address 4003 Blackpool Road Mr. Robert W. Leins Rockville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) <i>Consequence of Chronic Blood Pressure</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington		20g. (County) D.C.		20h. (State) D.C.	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 17, 1961</i> to <i>Oct 3, 1961</i> that (I) (we) last saw the deceased alive on <i>Sept 17, 1961</i> and that death occurred at <i>12:00 P.M.</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>John S. Rogers M.D.</i>		22b. DATE SIGNED <i>Oct 4, 1961</i>			
22c. PHYSICIAN'S NAME (Type) JOHN S. ROGERS		22d. ADDRESS <i>1719 Spring Rd</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/61		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery	
23d. LOCATION (City, town or county) Washington		23e. (State) D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>		24a. REC'D BY REGISTRAR OCT 5 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>	

11013

11013

M

1

Continued from page 11012

John

May 19 1903

1903

11013

Received of Mr. J. H. ...
the sum of ...
for ...

TO INITIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11619

CERTIFICATE OF DEATH

11605

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b 12201 Glen Mill Road d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12201 Glen Mill Road		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 12201 Glen Mill Road	
3. NAME OF DECEASED (Type or print) Elizabeth R Lepley		4. DATE OF DEATH Oct. 13 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 7 Days 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Reilly		14. MOTHER'S MAIDEN NAME Rose Mapes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. ADDRESS None		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO (b) Coronary arteriosclerosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Cerebral arteriosclerosis; CVA - 4 years ago	
19. INTERVAL BETWEEN ONSET AND DEATH 1 week years years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to Oct. 13, 1961 , that (I) (was) last saw the deceased alive on Oct. 12, 1961 , and that death occurred at 1:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Thomas E. Curtin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas E. Curtin		22d. ADDRESS 4600 Connecticut Ave. N.W. Wash D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		25a. REC'D BY REGISTRAR Oct 16 '61	
ADDRESS 317 Pa. Ave., SE		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11111



11111

Rockville

Rockville

12301 Glen Hill Road

12301 Glen Hill Road



Leopold 12301 Glen Hill Road

Leopold 12301 Glen Hill Road

March 1888

March 1888

Ohio

Ohio

Ohio

Rose

Rose

No

No

Thomas E. Martin

Thomas E. Martin

CERTIFICATE OF DEATH

Reg. Dist. No. **11606****11620**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton 39	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2016 Glenhaven Place		d. STREET ADDRESS 2016 Glenhaven Place	
3. NAME OF DECEASED (Type or print) First MORRIS Middle B Last LEVY		4. DATE OF DEATH Month October Day 20 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1886
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer - Retired		10b. KIND OF BUSINESS OR INDUSTRY Poland	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Barnet Levy		14. MOTHER'S MAIDEN NAME Anna Esther Selensky	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-44-8580	
INFORMANT Sidney Levy		Address 2404 Lillian Dr., SS, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transition 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Parkinson's Disease DUE TO (c) 1 month 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 month 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/18/61 to 10/20/61 , that I last saw the deceased alive on 10/18/61 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Donald Nelson		ADDRESS (Street, city or town, state) DATE SIGNED 10620 Georgia Ave, Silver Spring, Md. 10/26/61	
PHYSICIAN'S NAME (Type) Dr. Donald Nelson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-22-61	22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	22d. LOCATION (City, town, or county) (State) Hyattsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons		ADDRESS 3501 14th St, NW	24a. REC'D BY REGISTRAR DATE OCT 24 '61
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

11020

RECEIVED BY THE

11020

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "BY THE" are visible.]

1
FOR STATE
HEALTH DEPT.
(M)
0977
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11621 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11607

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 25 d. STREET ADDRESS <u>8075 Georgia Ave.</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>John William Lewis</u>			4. DATE OF DEATH Month Day Year <u>October 27 1961</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6-17-1890</u>		9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plasterer</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>577-30-1397</u>		17. INFORMANT <u>Montgomery County Police</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) } (c) DUE TO <u>underlying cause last.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Blaszczak</u>		M.D. <u>FRANK J. Blaszczak</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Blaszczak</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-30-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/2/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington County, Virginia</u>	
22d. LOCATION (City, town, or country) <u>Silver Spring, Md.</u>		22e. REGISTERED BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1834

14

CERTIFICATE OF DEATH

Reg. Dist. No. 11608

11622

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakema Park 12</u>				c. LENGTH OF STAY IN lb <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>12209 Bushey Drive 1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ethel Blanche Locke</u>				4. DATE OF DEATH Month Day Year <u>October 29, 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-29-76</u>	
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Not Known Collins</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>Not Known</u>			
17. INFORMANT <u>Hospital record</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X</u> DUE TO <u>Leukemic Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>carcinoma of pancreas</u> DUE TO (c) <u>with metastasis to liver</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> Embrown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystitis, Cholelithiasis & Sensitivity</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 19, 1960</u> to <u>Oct 29, 1961</u> , that I last saw the deceased alive on <u>Oct 28, 1961</u> , and that death occurred at <u>2:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u> DATE SIGNED <u>Oct 29, 1961</u>							
ACTUAL SIGNATURE <u>Philip E. Jones</u>				M.D. <u>Silver Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/31/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Hines Co.</u>				ADDRESS <u>2901-14th St. N.W.-D.C.</u>		24a. REC'D BY REGISTRAR <u>OCT 31 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO BE FILLED BY THE REGISTRAR: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/11/1918

LESTERICK DECK DRIFT

11/11/1918

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11623 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11609

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>md</u>		b. COUNTY <u>Montg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6800 Laverrock ct</u>		e. STREET ADDRESS <u>6800 Laverrock ct</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) <u>Janet Olson Love</u>		4. DATE OF DEATH <u>Oct 8 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-14-31</u>		9. AGE (In years last birthday) <u>30</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Louis M. Olson</u>	
14. MOTHER'S MAIDEN NAME <u>Janet Innes</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Carl Love</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>									
DUE TO (b) <u>Residual Rheumatic heart disease</u>									
DUE TO (c) <u>416X</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-8-61									
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipment</u>									
22b. DATE THEREOF <u>10/10/61</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>									
22d. LOCATION (City, town, or country) (State) <u>Chicago, Illinois</u>									
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>									
24a. REC'D BY REGISTRAR <u>OCT 13 '61</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11624

11610

1. PLACE OF DEATH COUNTY Montgomery County				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 7½ hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS Rt. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lloyd, Harry Lee Loyd				4. DATE OF DEATH Month October Day 6 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-99	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern owner		10b. KIND OF BUSINESS OR INDUSTRY Tavern owner		11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Loyd				14. MOTHER'S MAIDEN NAME Sarah Mitchell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 		17. INFORMANT Hospital records		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia (bilateral) 5811 DUE TO Hepatic coma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Saenence Cirrhosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 48 hrs INTERVAL BETWEEN ONSET AND DEATH 48 hrs							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 10/6/61 to 10/6/61 , that (I) (we) last saw the deceased alive on 10/6/61 and that death occurred at 10/6/61 M. from the causes and on the date stated above. 22a. SIGNATURE John P. Martin MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) John P. Martin, M.D. 22d. ADDRESS 22b. DATE SIGNED 10/6/61							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-10-61		23c. NAME OF CEMETERY OR CREMATORY Boyd Cemetery		23d. LOCATION (City, town or county) (State) Boyd. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.				25a. REC'D BY REGISTRAR OCT 10 '61		25b. REGISTRAR'S SIGNATURE Charles S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

11024

Montgomery County

John A. Smith

John A. Smith

Montgomery County Hospital

John A. Smith

John A. Smith

John A. Smith

11-30-33

John A. Smith

John A. Smith

John A. Smith

John A. Smith

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John A. Smith

John A. Smith

(1)

John A. Smith
11-30-33
John A. Smith

John A. Smith
11-30-33
John A. Smith

John A. Smith
11-30-33
John A. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11611											
1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 33 days 12 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium 2nd Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE District of Columbia b. COUNTY Northeast c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1723 Jackson Street					
3. NAME OF DECEASED (Type or print) Jesse Nesbit Lutton						4. DATE OF DEATH Month October Day 12 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 8, 1888		9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 4 Days 7 Hours 23 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor				10b. KIND OF BUSINESS OR INDUSTRY Engraving Bureau of				11. BIRTHPLACE (County & State, or foreign country) District of Columbia			
13. FATHER'S NAME James Lutton				14. MOTHER'S MAIDEN NAME Ella Grant				12. CITIZEN OF WHAT COUNTRY? United States			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Patient's record		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157 X Carcinoma of the pancreas with generalized metastasis DUE TO (b) 4 months DUE TO (c) 4 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 6/15 p.m. 10/12 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 6/15/61 to 10/12/61 , that (I) (no) last saw the deceased alive on 10/11/61 , and that death occurred at 2:30 M., from the causes and on the date stated above. 22a. SIGNATURE Hugh Irey 22b. DATE SIGNED October 12, 1961 22c. PHYSICIAN'S NAME (Type) Hugh Irey 22d. ADDRESS 7501 Riggs Rd. Lewis & Clark Md. 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 23a. BURIAL, CREMATION, REMOVAL, or disposal burial 23b. DATE THEREOF 10/16/61 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery 23d. LOCATION (City, town or county) (State) Ft. Myer, Virginia 24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W., 25a. REC'D BY REGISTRAR DATE OCT 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines											

2

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11625

11612

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JAKOMA PARK</u> c. LENGTH OF STAY in 1b <u>2 mos 1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brush Jan & Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>910 Sligo Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>BERTHA MARIAM MARDEN</u>				4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>1961</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-28-98</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Thomas V. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Reeves</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Hosp Record.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Glennocarcinoma of Gall Bladder</u> DUE TO (b) <u>Extensive secondary metastases to Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>155.1</u>												INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>3 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> , 19 <u>35</u> <u>Oct 8</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> , 19 <u>61</u> , and that death occurred at <u>10:15</u> PM, from the causes and on the date stated above.															
22a. SIGNATURE <u>Kenneth Laughlin</u>				22b. DATE SIGNED <u>10-8-61</u>				22c. PHYSICIAN'S NAME (Type) <u>924 Ellsworth Ave Silver Spring Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Name) <u>Burial</u>				23b. DATE THEREOF <u>10/12/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				23d. LOCATION (City, town or county) <u>Washington, D.C.</u> (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u>				25a. REC'D BY REGISTRAR <u>DATE 10/19/61</u>				25b. REGISTRAR'S SIGNATURE <u>A 376 G. Scholten</u>							

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXAMINED WITHIN 24 HOURS AFTER DEATH. PAGE 4 MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

OCT 13 '61

C. H. K. K. K.

2511



1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11627

Item 23b Film G300 11/10/61 mh

11613

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Hampton</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampton</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>			d. STREET ADDRESS <u>203 4th Street</u>		
3. NAME OF DECEASED (Type or print) <u>Gary</u> <u>Lee</u> <u>Maricle</u>			4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1961</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1943</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Serviceman</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		9. AGE (In years last birthday) <u>18</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <u>William Maricle</u>			14. MOTHER'S MAIDEN NAME <u>Gladys Marie Miller</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Aug 24 60 to present</u>			16. SOCIAL SECURITY NO. <u>present</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency</u> DUE TO (b) <u>Metastatic rhabdomyosarcoma</u> DUE TO (c) <u>6 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Sept. 8, 1961</u> to <u>October 31, 1961</u> , that (X) (we) last saw the deceased alive on <u>October 31, 1961</u> , and that death occurred at <u>3:10 AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>William P. Baker</u>			22b. DATE SIGNED <u>October 31, 1961</u>		
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM P. BAKER LT MC USN</u>			22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 1, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hampton Cemetery</u>	
23d. LOCATION (City, town or county) <u>Hampton, Iowa</u>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>			24b. ADDRESS <u>WASHINGTON, D.C.</u>		
25a. REC'D BY REGISTRAR DATE <u>NOV 6 '61</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11628

11614

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 hr 16 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash SAN + Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mt Rainier</u> d. STREET ADDRESS <u>3600 Rhode Island Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Matera</u>		4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-03</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>5</u> Min. <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Plate Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash N.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raffaele Matera</u>		14. MOTHER'S MAIDEN NAME <u>Stella Famiglietti</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2210 N. Capital</u>	
17. INFORMANT <u>Leonora Matera</u>		Address <u>2210 N. Capital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>acute myocardial infarction</u> DUE TO (c) <u>2 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Oct 26</u> , 19 <u>61</u> , that (I) (was) last saw the deceased alive on <u>Oct 26</u> , 19 <u>61</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James C Mandes</u> M.D. 22b. PHYSICIAN'S NAME (Type) <u>JAMES C MANDES</u>		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1401 16th St. N.W., WASH DC</u>	
22e. DATE SIGNED <u>10/26/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>OCT 30, 1961</u>		23b. DATE THEREOF <u>MT. OLIVET CEMETERY</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON, DC</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>N. Haulon</u> ADDRESS <u>4748 Wisc. Ave NW</u>		25a. REC'D BY REGISTRAR <u>OCT 31 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

11028

(M)

(1)

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11629

11615

Item 7 Film 6297 10/17/61 ink

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chandler Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>Matthews</u> Middle <u>Matthews</u> Last		4. DATE OF DEATH <u>Oct 5</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 4 1881</u> 18 <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Alice Matthews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause best fitting for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Passive congestion</u> DUE TO (c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 2 1961</u> to <u>Oct 4 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 4 1961</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Webster Sewell</u> M.D.		22b. DATE SIGNED <u>10-6-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Asa Memorial</u>	23d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md</u>		25. REC'D BY REGISTRAR DATE <u>OCT 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Truax</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL						2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAYTON d. STREET ADDRESS 13X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROLAND First (NMN) Middle MATTHEWS Last			4. DATE OF DEATH OCTOBER Month 10 Day 19 61 Year			9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARM WORKER		
5. SEX MALE			6. COLOR OR RACE NEGRO			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1-2-1880		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARM WORKER			10b. KIND OF BUSINESS OR INDUSTRY MARYLAND			11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? MARYLAND		
13. FATHER'S NAME NOT GIVEN			14. MOTHER'S MAIDEN NAME NOT GIVEN			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) UNKNOWN			16. SOCIAL SECURITY NO. HOSPITAL RECORDS		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Uremia DUE TO (b) Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Peritonitis due to strangulated left inguinal hernia						INTERVAL BETWEEN ONSET AND DEATH 12 hours 5 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State) 10-10-61 10-10 1961		
21. I certify that (I) (this hospital) attended the deceased from 10-10-61 to 10-10-61 , that (I) (we) last saw the deceased alive on 10-10-61 , and that death occurred at 10-10-61 , from the causes and on the date stated above.											
22a. SIGNATURE Charles S. Whitaker, M.D. M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10/11/61		
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D.						22d. ADDRESS Charlesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/14/61			23c. NAME OF CEMETERY OR CREMATORY Ash Memorial.,			23d. LOCATION (City, town or county) (State) Sandy Spring, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.						25a. REC'D BY REGISTRAR DATE OCT 17 '61			25b. REGISTRAR'S SIGNATURE Charles S. Whitaker		

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UNKNOWN

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10-10-10

CHARLES J. ...

CHARLES J. ...

CHARLES J. ...

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.

CERTIFICATE OF DEATH

11631

11617

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>bda 25 min</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12500 Two Farm Drive</u>			
5. NAME OF DECEASED (Type or print) <u>Leo Emanuel Mauchamek</u> First Middle Last				4. DATE OF DEATH <u>October 22 1961</u> Month Day Year			
3. NAME OF DECEASED (Type or print)	5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19 1914</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Transit</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>David Mauchamek</u>	14. MOTHER'S MAIDEN NAME <u>Ica Keyser</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>274-18-9009</u>		17. INFORMANT <u>Hospital Record</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN stem compression</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Suspected intracerebral haemorrhage</u> (c) <u>Suspected intracranial aneurysm</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 days</u> <u>6 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10/16 1961</u> to <u>10/22 1961</u> , that (I) (we) last saw the deceased alive on <u>10/22 1961</u> , and that death occurred at <u>10:55 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>John T. Hord</u>				22b. DATE SIGNED <u>10/23/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>John T. Hord MD</u>				22d. ADDRESS <u>1015 Spring St. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/26/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George's County, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zisk</u> Warner E. Pumphrey, Inc. Silver Spring, Maryland				25a. REC'D BY REGISTRAR <u>OCT 25 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

VR A15 (4)
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JAN 11 1961
U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11618

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 49 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 50 Chevy Chase d. STREET ADDRESS 8414 Lynwood Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Regina Meany Mayer			4. DATE OF DEATH Month October Day 2 Year 19 61		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH November 16, 1957		9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert C. Mayer			
14. MOTHER'S MAIDEN NAME Regina C. Meany		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)			
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas septicemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute Lymphocytic Leukemia (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 4 days 22 months					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from August 14, 1961 to October 2, 1961 that (I) (we) last saw the deceased alive on October 2, 1961 , and that death occurred at 4:55 PM from the causes and on the date stated above.					
22a. SIGNATURE J. David Heywood 22c. PHYSICIAN'S NAME J. DAVID HEYWOOD, M.D. 22b. DATE SIGNED 10/3/61 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION (City, town or county) (State) Washington, D. C.		24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland 25a. REC'D BY REGISTRAR OCT 6 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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Robert A. Fugate, Bethesda, Maryland

Mr. Oliver Cemetery

Washington, D. C.

DAVID RYMOND, N.D.

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10/3/61

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22 months

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11633

11619

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9200 Old Georgetown Rd. Alta Vista Nursing Home		d. STREET ADDRESS 3945 Conn. Avenue, N.W.	
3. NAME OF DECEASED (Type or print) First CARRIE Middle LEE Last McCormick		4. DATE OF DEATH Month October Day 3 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1863
9. AGE (In years last birthday) 98		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME LEMUEL YERBY		14. MOTHER'S MAIDEN NAME JANE COUTTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Records at Nursing Home-Same #1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 2 19 61 , to Oct 3 19 61 , that (I) (we) last saw the deceased alive on Oct 1 19 61 , and that death occurred at 4:55 P M, from the causes and on the date stated above.			
22a. SIGNATURE DeWitt E. DeLawter		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DEWITT E. DELAWTER, M.D.		22d. ADDRESS 8025 ABERDEEN RD. Bethesda, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/61	
23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		23d. LOCATION (City, town, or county) (State) Richmond, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Company-2901 14th St., N.W.		25a. REC'D BY REGISTRAR DATE OCT 5 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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CERTIFICATE OF DEATH

1973

1. Name of deceased: JAMES J. JERRY
2. Date of birth: [illegible]
3. Date of death: [illegible]
4. Place of birth: [illegible]
5. Place of death: [illegible]
6. Cause of death: [illegible]
7. Signature of physician: [illegible]
8. Signature of registrar: [illegible]
9. Date of registration: [illegible]
10. Registrar's name: [illegible]

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FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

Items 20&21 Film 299
11-1-61 ans

299
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11634 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11620

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4013 Saul Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 41 Kensington
d. STREET ADDRESS 4013 Saul Road e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Helen Middle Maxine Last McNenth

4. DATE OF DEATH
Month Oct Day 24 Year 1961

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 10-28-17 9. AGE (In years last birthday) 43 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Arkansas 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Glover 14. MOTHER'S MAIDEN NAME Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT (James J. McNenth) husband Address same as above

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Synergistic poisoning
973.3 DUE TO Carbon monoxide, alcohol & barbiturates
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) — DUE TO (c) —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OF CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschaw M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 10-24-61
EXAMINER'S NAME (Type) FRANK J. Broschaw Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10/27/61 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 22d. LOCATION (City, town, or country) (State) Rockville, Maryland

23. FUNERAL DIRECTOR ADDRESS Robert A. Pumphrey, Bethesda, Maryland 24a. REC'D BY REGISTRAR OCT 26 '61 24b. REGISTRAR'S SIGNATURE Charles S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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(I)

Robert A. Pashney, Secretary, Maryland

Bartholomew, Pennsylvania

Bartholomew, Pennsylvania

CERTIFICATE OF DEATH

Reg. Dist. No.

11621

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Wisconsin</u> b. COUNTY <u>86x-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Milwaukee</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Hosp. & Sanitarium</u>		d. STREET ADDRESS <u>86x-3</u>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>MEYER</u> Last <u>MEYER</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 13, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>5</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Mohr</u>		14. MOTHER'S MAIDEN NAME <u>Albertina Mohr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Record</u>		Address <u>NONE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 260X DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 22, 1957</u> , to <u>Oct. 18, 1961</u> , that I last saw the deceased alive on <u>Oct. 18, 1961</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond Bradshaw</u>		ADDRESS (Street, city or town, state) <u>345 University Blvd., W. Silver Spring, Md.</u> DATE SIGNED <u>OCT 19 1961</u>	
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, M.D., 345 University Boulevard West, Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 23/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>—</u>	22d. LOCATION (City, town, or county) (State) <u>MILWAUKEE, WISC.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hysony Bo.</u>		ADDRESS <u>Wash. D.C. 1300-N ST.-N.W.</u>	24a. REC'D BY REGISTRAR <u>OCT 20 '61</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MONTGOMERY

11623

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Dist. D.C.</u> b. COUNTY <u>Mont. organ</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>4714 - Chesapeake St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Arthur Paul Moore</u>		4. DATE OF DEATH <u>Oct. 19 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25, 1891</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanics</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto repair</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Clara Wolfe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Army soldier</u>		16. SOCIAL SECURITY NO. <u>1-23-456789</u>	
17. INFORMANT <u>Gladyt Moore</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> (c) <u>Coronary Atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>4 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>September 19 1961</u> to <u>Oct 19 1961</u> , that (I) (we) last saw the deceased alive on <u>October 19 1961</u> , and that death occurred at <u>9:25</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Michel M. Healy</u>		22b. DATE SIGNED <u>10/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>MICHEL M HEALY</u>		22d. ADDRESS <u>WASHINGTON CLINIC WASH DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/23/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lakeside M. E. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Dover, Delaware</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Oct 23 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MAYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
CERTIFICATE OF DEATH																							
11636																							
11622																							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18 Hamilton St. N.W.</u> d. STREET ADDRESS <u>47 X-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Dorothy Hetzel Miller</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1961</u>																			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-20-79</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>Gabriel Eisenhart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Swinford</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>											
17. INFORMANT <u>Mr. Fred J. Miller</u>				Address <u>8717 - 23 rd Avenue, Adelphi, Maryland</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> 4 4 3 X DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u> <u>unknown</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>3-4</u> , 19 <u>59</u> , to <u>10-16</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10-16</u> , 19 <u>61</u> , and that death occurred at <u>9:32</u> A.M., from the causes and on the date stated above.																							
22a. SIGNATURE <u>E.IND MAGI</u>				M.D. <u> </u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>10-16-61</u>											
22c. PHYSICIAN'S NAME (Type) <u>E.IND MAGI</u>				22d. ADDRESS <u>918 University Blvd. E. Silver Spring, Md.</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/19/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Prince George's County, Md.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumfrey, Inc.</u>				ADDRESS <u>434 Georgia Avenue, Silver Spring, Maryland</u>				25a. REC'D BY REGISTRAR <u>Oct 18 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

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FOR STATE
HEALTH DEPT.

TO THE DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 days		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
3. NAME OF DECEASED (Type or print) Douglas Dean Moore		4. DATE OF DEATH October 5 19 61		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 28, 1909		9. AGE (In years last birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces		10b. KIND OF BUSINESS OR INDUSTRY U. S. Air Force		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. Hospital records	
17. INFORMANT Hospital records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending</u> Broncho-pneumonia, hemorrhagic, bilateral 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH ?		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCART, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED October 5, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10 Oct 1961		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) Arlington Va.			
23. FUNERAL DIRECTOR THE J. H. HINES 2901 14th St N.W. Wash.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11639 CERTIFICATE OF DEATH 11625

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1516 Oakview Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lena Ann Morris</u>		4. DATE OF DEATH <u>10 - 5 - 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-90</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer Bradway</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Henry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerotic Cardiovascular Disease</u> (a), stating the underlying cause last. DUE TO (c) <u>6 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <u>Jan 3, 1961</u> to <u>Oct 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 5, 1961</u> , and that death occurred at <u>11:35 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Merrill M. Cross</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10/5/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS MD.</u>		22d. ADDRESS <u>8248 Georges ave, Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>10/5/1961</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Wash D C</u>		23d. LOCATION (City, town or county) (State) <u>Springfield, Mass.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u>		25a. REC'D BY REGISTRAR <u>Oct 9 '61</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 1 of 2. Pages 1 and 2 should be filled with information obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information obtained by the funeral director. The State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11640

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11626

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2808 Terrace Drive		d. STREET ADDRESS 2808 Terrace Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SAM Middle NADLER Last NADLER		4. DATE OF DEATH Month Oct. Day 30 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1915
9. AGE (In years for birthday) yrs. 46		IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Multilith Operator		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Nadler		14. MOTHER'S MAIDEN NAME Gussie ----- Negelberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 057-10-7732	
17. INFORMANT Meanette Nadler		Address 2808 Terrace Dr, ChCh, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Ventricular Fibrillation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Coronary Occulsion DUE TO (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 min. 1 - 2 Hrs. 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-14 1957 to Oct 30 , 19 61 that (I) (we) last saw the deceased alive on Oct 28 , 19 61 , and that death occurred at 9:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE Benjamin Manchester		22b. DATE SIGNED Oct. 30, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Benjamin Manchester		22d. ADDRESS 3200 16th Street N.W., Wash., D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 1, 1961	
23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery		23d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home		ADDRESS 4217 9th Street N.W.	
25a. REC'D BY REGISTRAR NOV 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. H...	

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Signature

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11627

11641

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>seven years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3409 Floral Street,</u>				d. STREET ADDRESS <u>3409 Floral Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Lighter</u> Last <u>Nail</u>				4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>25 NOV 1882</u>	
9. AGE (In years last birthday) <u>78 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Counter Clerk-Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. John F. Nail</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Artery Sclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>57 yrs</u> <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>1958</u> , to <u>8 Oct</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8 Oct</u> , 19 <u>61</u> , and that death occurred at <u>8:45 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morton L. White</u>				ADDRESS (Street, city or town, state) <u>11134 Georgia Ave Silver Spring Md</u>			
DATE SIGNED <u>8 Oct 61</u>							
PHYSICIAN'S NAME (Type) <u>Raymond H. Ziskin</u>				ADDRESS <u>8434 Georgia Avenue</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/11/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Montgomery County, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>Silver Spring, Maryland</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>C. J. Hume</u>				DATE <u>OCT 10 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11628

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM & HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAM</u> Middle <u>NEIDORF</u> Last <u>NEIDORF</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1887</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ZEUS NEIDORF</u>		14. MOTHER'S MAIDEN NAME <u>ANNA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>WASH. SAN & HOSP RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE INFARCTION, SMALL AND LARGE BOWEL</u> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ATHEROSCLEROSIS OF THE AORTA</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHOLELITHIASIS AND GANGRENE OF GALL BLADDER.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> to <u>OCT 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>OCT 16, 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>B.P. LAFSKY</u>		22b. DATE SIGNED <u>OCT 16, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>B.P. LAFSKY</u>		22d. ADDRESS <u>2025-EYE ST. NW WASH. D.C.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ADAS ISRAEL CEM.</u>		23d. LOCATION (City, town or county) (State) <u>WASH. D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 18 '61</u>	
ADDRESS <u>4217 9th St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

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1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

2. In the second part of the paper, the structure of the atom is discussed in more detail. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

3. The third part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

4. In the fourth part of the paper, the structure of the atom is discussed in more detail. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

5. The fifth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

6. In the sixth part of the paper, the structure of the atom is discussed in more detail. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

7. The seventh part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

8. In the eighth part of the paper, the structure of the atom is discussed in more detail. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

9. The ninth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

10. In the tenth part of the paper, the structure of the atom is discussed in more detail. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11643						11629					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY MONTGOMERY MARYLAND						a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 25					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN HOSPITAL						d. STREET ADDRESS 8512 CEDAR STREET 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last EDWARD Marshall NEVILS						Month Day Year OCTOBER 30 1961					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 25, 1874		9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Manager-Retired Govt. Printing						10b. KIND OF BUSINESS OR INDUSTRY Tennessee			11. BIRTHPLACE (County & State, or foreign country) U.S.A.		
13. FATHER'S NAME John Nevils						14. MOTHER'S MAIDEN NAME Lydia Laws					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW1						16. SOCIAL SECURITY NO. 578-22-6085		17. INFORMANT Mrs. Evelyn D. Nevils			
						Address 8512 Cedar Street Silver Spring, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) CEREBRAL ATHEROSCLEROSIS (c), stating the underlying cause last, (c) DUE TO YEARS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MILD HYPERTENSION											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from OCT 29, 1961, to OCT 30, 1961, that (I) (we) last saw the deceased alive on OCT 29, 1961, and that death occurred at 5A M, from the causes and on the date stated above.											
22a. SIGNATURE James A. Roberts						22b. DATE SIGNED 10/30/61					
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS						22d. ADDRESS 8907 GEO. AVE. SILVER SPRING, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/1/61			23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Inc.						25a. REC'D BY REGISTRAR DATE OCT 31 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Evans		

11063

(M)

Regional Manager - United States

(1)

San Jose

Local Area

San Jose, Costa Rica

San Jose

San Jose

San Jose, Costa Rica

San Jose, Costa Rica

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MONTGOMERY COUNTY				MONTGOMERY COUNTY			
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 9401 Providence Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9101 Providence Street				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret Morris Norman				4. DATE OF DEATH Month October Day 30 Year 1961			
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 11, 1872		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher retired		10b. KIND OF BUSINESS OR INDUSTRY Delaware Schools		11. BIRTHPLACE (County & State, or foreign country) Lewes, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Norman				14. MOTHER'S MAIDEN NAME Annie W. Norman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. 163-10-3179			
17. INFORMANT Col. Chas. J. Norman				Address 9101 Providence Street Silver Spring, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of right breast (c) 170X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1959 to Oct. 30, 1961 , that (I) (we) last saw the deceased alive on Oct. 30, 1961 , and that death occurred at 9 A.M. from the causes and on the date stated above.							
22a. SIGNATURE J. Marion Bankhead M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct. 30, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. J. Marion Bankhead				22d. ADDRESS 9241 Columbia Boulevard,			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/61		23c. NAME OF CEMETERY OR CREMATORY Presbyterian Church		23d. LOCATION (City, town or county) (State) Sussex County, Lewes, Delaware	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Ziska				ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25a. REC'D BY REGISTRAR NOV 1 61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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VS. A15ME
5M 9/60

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NOTES
BY W. H. B. B. B. B.

Unknown

Robert A. Thompson, Wisconsin, Madison, Wisconsin, 1948

10.10.48 On Hill Cemetery

D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11646

CERTIFICATE OF DEATH

11632

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN tb <u>79 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>Vennings</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bert Adams Road</u> d. STREET ADDRESS <u>Bert Adams Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Purcell</u> First Middle Last <u>North</u>		4. DATE OF DEATH Month Day Year <u>October 12 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 12, 1932</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Armed Forces</u>		9b. AGE (In years last birthday) <u>28</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Armed Forces</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willie North</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Beasley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes Feb 1952 to Pres 260 60 5524</u>		16. SOCIAL SECURITY NO. <u>260 60 5524</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma in liver (primary unknown)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>156.1</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>> 5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Urinary tract infection</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>July 25</u> , 19 <u>61</u> to <u>Oct 12</u> , 19 <u>61</u> , that (X) (we) last saw the deceased alive on <u>Oct 12</u> , 19 <u>61</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John W. Brackett, Jr.</u> M.D.		22b. DATE SIGNED <u>12 Oct 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN W. BRACKETT, JR., LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Shipment</u>		23b. DATE THEREOF <u>14 Oct 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Unknown at present</u>		23d. LOCATION (City, town or county) (State) <u>Georgia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. F. TAYLOR</u>		25a. REC'D BY REGISTRAR <u>OCT 16 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		25c. ADDRESS <u>909 6th St. N.W. Washington, D. C.</u>	

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TO SPIRIT OR ATTENDING PHYSICIAN: The law requires that the death certificate be expedited within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
11647					11633				
Item 21 Film G292 10/13/61 iwk									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Montgomery					a. STATE Pennsylvania				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					b. COUNTY Wilkes-Barre				
c. LENGTH OF STAY IN 1b 7 Days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilkes-Barre				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center					d. STREET ADDRESS 33 West South Street				
3. NAME OF DECEASED (Type or print) ANNA MARION OBICI					4. DATE OF DEATH October 9, 1961				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH August 23, 1909				
9. AGE (In years last birthday) 52 yrs.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Frank Obici					14. MOTHER'S MAIDEN NAME Susie Yannocone				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II					16. SOCIAL SECURITY NO. None				
17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelogenous leukemia with involvement of spleen, kidneys, nodes, and large bowel DUE TO (b) Acute hemorrhage, large bowel DUE TO (c) Bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 204.1				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State) October 2, 1961 to October 9, 1961				
21. I certify that (I) (this hospital) attended the deceased from October 9, 1961 to October 9, 1961 , that (I) (we) last saw the deceased alive on October 9, 1961 , and that death occurred at 6:35 AM from the causes and on the date stated above.									
22a. SIGNATURE J. David Heywood M.D.					22b. DATE SIGNED 10-9-61				
22c. PHYSICIAN'S NAME (Type) J. David Heywood M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL					23b. DATE THEREOF 10-9-1961				
23c. NAME OF CEMETERY OR CREMATORY -					23d. LOCATION (City, town or county) (State) WILKES-BARRE, PA.				
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gaudin, Inc. 1756 Pa. Ave. NW Wash DC					25a. REC'D BY REGISTRAR OCT 11 '61				
25b. REGISTRAR'S SIGNATURE Arthur L. Kline									

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Montgomery

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The Clinical Center

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The Clinical Center, National

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
11648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11634												
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3305 PENDLETON DRIVE						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 3305 PENDLETON DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) EDWARD ANDREW O'NEILL						4. DATE OF DEATH Month OCTOBER Day 29 Year 1961						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 9, 1909		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER (MERKLE PRESS)				10b. KIND OF BUSINESS OR INDUSTRY PRINTING				11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME ANDREW O'NEILL						14. MOTHER'S MAIDEN NAME JOSEPHINE FAHEY						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. WW #2 044-07-8178		17. INFORMANT MRS. EDITH L. O'NEILL, 3305 PENDLETON DRIVE,				Address SILVER SPRING, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) MYOCARDITIS (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH SUDDEN DAYS		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Frank J. Broschart M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) FRANK J. BROSCART DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED OCT. 29, 1961												
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 10/31/61		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY			22d. LOCATION (City, town, or country) (State) ARLINGTON, VIRGINIA				
23. FUNERAL DIRECTOR Raymond A. Ziska Warner E. Pumphrey, Inc.						ADDRESS 8434 Georgia Avenue Silver Spring, Md.		24a. REC'D BY REGISTRAR OCT 31 '61 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Huns		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11649

CERTIFICATE OF DEATH

11635

1. PLACE OF DEATH e. COUNTY MONTGOMERY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Md d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wheaton Nursing Home		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland d. STREET ADDRESS 735 Sligo Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Caroline M. Osmann		4. DATE OF DEATH Month Oct. Day 28 Year 19 61	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker (retired)		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 81 yrs. 11. BIRTHPLACE (County & State, or foreign country) Walnut, Illinois
13. FATHER'S NAME Nicholas Ohlsen		14. MOTHER'S MAIDEN NAME Karen Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT Mrs. John P. Dee, 735 Sligo Ave., Silver Spring, (Md.)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 12, 1961 , to October 28, 1961 , that (I) (we) last saw the deceased alive on Oct. 28 1961 , and that death occurred at 3:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE Veronica Troost M.D.		22b. DATE SIGNED 10-28-1961	
22c. PHYSICIAN'S NAME (Type) VERONIKA TROOST		22d. ADDRESS 10236 N. H. Ave. Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 2, 1961	23c. NAME OF CEMETERY OR CREMATORY HILLS OF REST CEMETERY	23d. LOCATION (City, town or county) (State) SIOUX FALLS, SOUTH DAKOTA
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Ziska WARNER E. PUMPHREY, INC., SILVER SPRING, MD.		25a. REC'D BY REGISTRAR OCT 31 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO :

FROM :

SUBJECT :

REFERENCE :

REMARKS :

DATE :

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HONOLULU, HAWAII
FROM :
SUBJECT :
REMARKS :
DATE :
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11650

11636

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN lb 46 days		d. STREET ADDRESS 1405 28th. St., NW	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Francis Avery Packer		4. DATE OF DEATH Month October Day 27 Year 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 6, 1897
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY 561 38 0026	11. BIRTHPLACE (County & State, or foreign country) Newport, R.I.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Stephen Packer	
14. MOTHER'S MAIDEN NAME Harriette Jordan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI, WWII, Korea	
16. SOCIAL SECURITY NO. 561 38 0026		17. INFORMANT Address WIFE: Mrs. Bernice D. Packer, same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF THE KIDNEY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 12 1961 to October 27, 1961 that <input type="checkbox"/> (we) last saw the deceased alive on October 27, 1961 , and that death occurred at 2:25 PM from the causes and on the date stated above.			
22a. SIGNATURE William P. Urshel M.D.		22b. DATE SIGNED 27 October 1961	
22c. PHYSICIAN'S NAME (Type) WILLIAM P. URSHEL LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE JOSEPH CRAWLERS & SONS INC., Washington, D. C.		25a. REC'D BY REGISTRAR DATE NOV 1 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11651

CERTIFICATE OF DEATH

11651

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8013 - Hampden Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rosa M. Padgett</u>		4. DATE OF DEATH Month Day Year <u>Oct. 14 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>Washington, D.C. U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Richards</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alice Stewart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		17. INFORMANT <u>Alice Padgett / As Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation, Acute</u> 3 days 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial Degeneration, chronic</u> 5 yrs + (c) <u>Arteriosclerotic Heart Disease</u> 5 yrs + cause last. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>1) Complete Heart Block 2) Chronic Nephrosclerosis</u>			
22a. SIGNATURE <u>Stewart Clapp</u>		22b. DATE SIGNED <u>10-15-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		22d. ADDRESS <u>4740 Chevy Chase Dr</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Oct 19 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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11551

Robert A. Humphrey, Bethesda, Maryland, 10/11/51
Burial 10/11/51 St. Oliver Cemetery, Washington, D. C.

Stewart Clegg
Stewart W. Clegg

20 Oct 1951

Complete Heart Block, extreme hypotension

Atypical, atypical heart disease

Atypical, atypical, chronic

Myocardial Degeneration, Aortic

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11652

11638

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>13</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> d. STREET ADDRESS <u>12202 Grandview Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Maud Stella Parker</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>8</u> Year <u>1961</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswoman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel King</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Mason</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-05-9574</u>				17. INFORMANT <u>Welford D Hudson Samy</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 420.1 DUE TO (b) <u>Pulmonary embolism</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>Coronary thrombosis</u>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from <u>Sept 25, 1961</u> to <u>Oct 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 8, 1961</u> , and that death occurred at <u>10p</u> M., from the causes and on the date stated above.																			
22a. SIGNATURE <u>George H. Mitchell</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>Oct 8 1961</u>				22c. PHYSICIAN'S NAME (Type) <u>Mitchell, George</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/11/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Prince George's, Maryland</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Zarka</u>				ADDRESS <u>8434 Georgia Avenue</u>				25a. REC'D BY REGISTRAR <u>Oct 11 61</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>							
Warner E. Pumphrey, Inc.				Silver Spring, Maryland				DATE											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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Handwritten notes and signatures, including "George H. Mitchell" and "George H. Mitchell".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11653											
11639											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>3 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1705 East-West Highway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>PEARLMAN</u> Last <u>PEARLMAN</u>						4. DATE OF DEATH Month <u>Oct</u> Day <u>15</u> Year <u>1961</u>					
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 15, 1889</u>		9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>			
13. FATHER'S NAME <u>Benjamin Rodman</u>						14. MOTHER'S MAIDEN NAME <u>SARAH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						17. INFORMANT <u>ALBERT PEARLMAN</u> Address <u>4426 Springdale Sim</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CARDIAC THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of Myocardium</u> (c) <u>MYOCARDIAL INFARCT 5-7D</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>10/15</u> , 19 <u>61</u> , that (I) (<u>no</u>) last saw the deceased alive on <u>10/15</u> , 19 <u>61</u> , and that death occurred at <u>2:25</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Irving W. Wink</u> M.D.						22b. DATE SIGNED <u>10/16/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>Irving W. Wink</u>						22d. ADDRESS <u>3900 McKinley St. N.W.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>10/17/1961</u>			23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM.</u>			23d. LOCATION (City, town or county) (State) <u>Hyattsville, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Fennell</u> ADDRESS <u>4217-9th St NW</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 18 '61</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11654

CERTIFICATE OF DEATH

11640

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 29 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST FRIENDSHIP d. STREET ADDRESS PFEFFERKORN ROAD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) SAMUEL LOUIS PFEFFERKORN		4. DATE OF DEATH 10 16 19 61		5. SEX MALE WHITE WIDOWED DIVORCED		6. COLOR OR RACE WHITE WIDOWED DIVORCED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 4/3/1896		8. DATE OF BIRTH 65 yrs.		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY COFFEE MERCHANT				11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ALBERT PFEFFERKORN				14. MOTHER'S MAIDEN NAME CECELIA EINSTIEN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. -				17. INFORMANT HOSPITAL RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (b) Coronary Thrombosis (c) Coronary Thrombosis DUE TO Coronary Thrombosis (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 24 hrs 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dark urinary retention due to prostatic hypertrophy																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -				20f. (City or town) 9/17, 1961 to 10/16, 1961 (County) CLARKSVILLE (State) MD.							
21. I certify that (I) (this hospital) attended the deceased from 9/17, 1961 to 10/16, 1961 , that (I) (we) last saw the deceased alive on OCTOBER 16, 1961 , and that death occurred at 10 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE Charles S. Whitaker M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS CLARKSVILLE, MD.				22b. DATE SIGNED 10-17-61											
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10-19-61				23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS				23d. LOCATION (City, town or county) (State) ELLICOTT CITY Md.							
24. FUNERAL DIRECTOR'S SIGNATURE F.C. HIGINBOTHAM				ADDRESS 0M, ELLICOTT CITY Md				25a. REC'D BY REGISTRAR OCT 19 '61				25b. REGISTRAR'S SIGNATURE Charles S. Whitaker							



11654

11654

HOWARD

NATLANE

WINTHROP

WEST TIREBOMIT

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CLIFF

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WINTHROP GENERAL HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11655

11641

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN lb 2 hrs. 15 min. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1605 Bucknell Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs Sina Jennie Pike		4. DATE OF DEATH Month October Day 20 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1870	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Holland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME M. Brunswick		14. MOTHER'S MAIDEN NAME Elizabeth Cowe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Washington Sanitarium and Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive + Arteriosclerotic Heart Disease long duration DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 4 hours					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) June	
20f. (City or town) June		20g. (County) June		20h. (State) June	
21. I certify that (I) (this hospital) attended the deceased from June 1955 to Oct. 20 , 1961, that (I) (we) last saw the deceased alive on Oct. 20 , 1961, and that death occurred at 6:00 PM , from the causes and on the date stated above.					
22a. SIGNATURE Benjamin Isaacson		22b. DATE SIGNED 10/20/61		22c. PHYSICIAN'S NAME (Type) BENJAMIN ISAACSON	
22d. ADDRESS 7733 Alaska Ave. W. Washington 12-D		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial		23b. DATE THEREOF 10/24/61		23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery	
23d. LOCATION (City, town or county) Rochester, New York		23e. (State) New York			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Wiska		24a. ADDRESS 8434 Georgia Avenue		24b. DATE OCT 24 '61	
24c. NAME OF FUNERAL HOME Warner E. Pumphrey, Inc.		24d. ADDRESS Silver Spring, Maryland		24e. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RECORDS AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11656

CERTIFICATE OF DEATH

Item 1 Film G297 10/9/61 ink

11642

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson	
c. LENGTH OF STAY IN 1b 4 1/2 mos.		d. STREET ADDRESS Route #2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pvt. home of daughter (Mrs. Nellie Peter) 9806 Bristol Ave.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Ellen Last Poole		4. DATE OF DEATH Month 10 Day 2 Year 1961	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-9-81
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Prolesville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Jefferson Reed		14. MOTHER'S MAIDEN NAME Hattie Norris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Mesenteric Occlusion 450.0 DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute thrombosis Rt. Popliteal Artery.			
INTERVAL BETWEEN ONSET AND DEATH 6 hours 10 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 11-11-1957 to 10-2-1961 , that (I) (the) last saw the deceased alive on 10-2-1961 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE N.C. Shoemaker M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) N.C. Shoemaker M.D.		22d. ADDRESS 8005 Woodbury Br. Silver Spring Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/5/61	
23c. NAME OF CEMETERY OR CREMATORY MONOCACY CEMETERY		23d. LOCATION (City, town or county) (State) Beallsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William C. Hilton, Baltimore, Md.		25a. REC'D BY REGISTRAR OCT 5 '61	
25b. REGISTRAR'S SIGNATURE Christina S. Thomas			

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Mr. T. J. ...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11657

11643

1. PLACE OF DEATH a. COUNTY Montg MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 07 Gaithersburg			
c. LENGTH OF STAY IN 1b 41 yrs				d. STREET ADDRESS 15 DeSellum St			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Middleton Pope				4. DATE OF DEATH Month Day Year Oct 17th 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1903	
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days 4 0		11. IF UNDER 24 HRS. Hours Min. 4 0		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret-Store Clerk				10b. KIND OF BUSINESS OR INDUSTRY Med,			
11. BIRTHPLACE (County & State, or foreign country) Montgomery Co. Md.				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Thomas Pope				14. MOTHER'S MAIDEN NAME Annie V. Stephens			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Virginia D. Pope. AS No 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, STOMACH WITH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) METASTASES, LIVER DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 1/2 MONTHS 4 WEEKS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1961 to Oct. 17, 1961 , that (I) (we) last saw the deceased alive on Oct. 13, 1961 , and that death occurred 10:30 PM from the causes and on the date stated above.							
22a. SIGNATURE Philip R. James				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Philip R. James				22d. ADDRESS WASHINGTON CLINIC, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-20-61		23c. NAME OF CEMETERY OR CREMATORY Damascus Cemetery		23d. LOCATION (City, town or county) (State) Damascus. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.				25. REC'D BY REGISTRAR Gaithersburg. Md.			
25a. DATE OCT 20 '61				25b. REGISTRAR'S SIGNATURE Charles S. Hume			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11644

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

07

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Mont. Co.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 8 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 42 Glen Echo Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban			d. STREET ADDRESS 1 6216-Walhonding Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charlotte Middle W. Last Potter			4. DATE OF DEATH Month October Day 1 Year 1961		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1889	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Paul, Minn.	
13. FATHER'S NAME William Waugh			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT Virginia Potter (daughter in law)			17. ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Fracture of left femur DUE TO (c) 1 week					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor at home fracturing left hip			
20c. TIME OF INJURY Month, Day, Year 2:45 a.m. 9/23/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20f. (City or town) Glen Echo Hts		20g. (County) Montg		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/2/61	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Suitland, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/3/61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
22d. LOCATION (City, town, or country) Suitland, Maryland		22e. (State) Md.			
23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland			24a. REC'D BY REGISTRAR OCT 4 '61		
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11659

CERTIFICATE OF DEATH

Items 13 & 14 Film G297 10/11/61 ink

11645

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Mont. A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban				d. STREET ADDRESS ---			
3. NAME OF DECEASED (Type or print) First Minette Middle B. Last Prigg				4. DATE OF DEATH Month 10 Day 3 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/24/99	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 02 Days X-2		IF UNDER 24 HRS. Hours 19 Min. 61		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY D. C.			
11. BIRTHPLACE (County & State, or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William C. Burton Bergmann				14. MOTHER'S MAIDEN NAME Helena Kunzig Bergmann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMATION William B. Prigg, husband same as above				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 154X IMMEDIATE CAUSE (a) cardiac fibrillation (arrhythmia) DUE TO (b) toxicology, peritonitis DUE TO (c) advanced carcinomatosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) prolapsed Co. rectum, old peritonitis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9:26 a.m., 1961 to 10:35 a.m., 1961 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 10:35 a.m. from the causes and on the date stated above.							
22a. SIGNATURE John O. Robben M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John O. Robben				22d. ADDRESS Maryland 1015 Spring Street, Silver Spring,			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Prince Georges County, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Sheila H. King Co. Wash. D.C.				25a. REC'D BY REGISTRAR OCT 5 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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101. Spring Lake, Illinois, 1901
102. Spring Lake, Illinois, 1901
103. Spring Lake, Illinois, 1901
104. Spring Lake, Illinois, 1901
105. Spring Lake, Illinois, 1901
106. Spring Lake, Illinois, 1901
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110. Spring Lake, Illinois, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11660
11646
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission) e. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 3048 Buchanan St., Apt. A2	
3. NAME OF DECEASED (Type or print) John Lawrence Ramsey		4. DATE OF DEATH Month Day Year October 24, 1961	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NAV WWI		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Lodwick Ramsey		14. MOTHER'S MAIDEN NAME Katherine Blankenship	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWI		16. SOCIAL SECURITY NO.	
17. INFORMANT WIFE: Mrs. Marion Ramsey, same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Rt Lung DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from September 25, 1961, to October 24, 1961, that (X) (we) last saw the deceased alive on October 24, 1961, and that death occurred at 3:30 PM from the causes and on the date stated above.			
22a. SIGNATURE James L. Beeby		22b. DATE SIGNED 25 October 1961	
22c. PHYSICIAN'S NAME (Type) JAMES L. BEEBY LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 27, 1961	
23c. NAME OF CEMETERY OR CREMATORY Fair View Cemetery		23d. LOCATION (City, town or county) (State) Roanoke, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home		25a. REC'D BY REGISTRAR DATE OCT 26 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

11000

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1

CERTIFICATE OF DEATH

Reg. Dist. No. 11647

11661

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hungerford Town, Rockville</u>				c. LENGTH OF STAY IN 1b <u>1 Year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#3 - Crothers Court</u>				d. STREET ADDRESS <u>#3 - Crothers Court</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>H.</u> Middle <u>Reed</u> Last				4. DATE OF DEATH <u>10-31-1961</u> Month <u>10</u> Day <u>31</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 21, 1876</u> 84	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James H. Godfrey</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Donaldson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
INFORMANT <u>Mrs. Helma R. Dunn</u>				Address <u>above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Senility</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/10</u> , 19 <u>41</u> , to <u>10/31</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>10/24</u> , 19 <u>61</u> , and that death occurred at <u>11:00</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2716 Kirkwood Place</u> DATE SIGNED <u>Earl W. Graeff</u>							
ACTUAL SIGNATURE <u>Earl W. Graeff</u>				M.D. <u>W. Hyattville, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 3/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home</u>				ADDRESS <u>1701</u>		24a. REC'D BY REGISTRAR <u>Nov 6 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11662

11648

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY Jacksonville	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville	
c. LENGTH OF STAY IN 1b 43 days		d. STREET ADDRESS 1596 Lancaster Terrace	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle Aston Last Rhodes		4. DATE OF DEATH Month October Day 23 Year 19 61	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 4, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Virginia
13. FATHER'S NAME Samuel Aston		14. MOTHER'S MAIDEN NAME Elizabeth Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17. INFORMANT HUS: William K. Rhodes, same as #2	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO (b) Carcinoma of the lungs with metastases Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) and pleural effusion - malignant		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that XX (this hospital) attended the deceased from September 11 19 61 to October 23 19 61 , that (I) (we) last saw the deceased alive on October 23 19 61 , and that death occurred at 12:57 PM from the causes and on the date stated above.	
22a. SIGNATURE B. M. SHEPARD M.D.	22b. DATE SIGNED 24 October 19 61
22c. PHYSICIAN'S NAME (Type) B. M. SHEPARD LT MC USN	22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF Oct 25 1961	23c. NAME OF CEMETERY OR CREMATORY Ceder Hill Crematory	23d. LOCATION (City, town or county) (State) Suitland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR OCT 26 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Hines

1163

CLASS DATE OF DEATH

1163

(M)

Florida
L. C. ...
...
U. S. ...

(1)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11663

11649

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, d. STREET ADDRESS 11302 Dewey Road, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robin Dale Middle Rhodes Last Rhodes		4. DATE OF DEATH Month October Day 7, Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1961
9. AGE (In years last birthday) 9		10. IF UNDER 1 YEAR Months 35	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? 9 32	
13. FATHER'S NAME Thomas Brown Rhodes, Jr.		14. MOTHER'S MAIDEN NAME Helen Carol Argenbright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT father		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TWIN BIRTH - HYALINE MEMBRANE 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 12 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/7 to 10/7 , 19 61 , that (I) (we) last saw the deceased alive on 10/7 , 19 61 , and that death occurred at 9:50 A. M., from the causes and on the date stated above.			
22a. SIGNATURE Dr. Herbert H. Diamond		22b. DATE SIGNED 10/13/61	
22c. PHYSICIAN'S NAME (Type) HERBERT H. DIAMOND		22d. ADDRESS 911-SILVER SPRING AVE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia MD	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		25a. REC'D BY REGISTRAR DATE OCT 13 '61	
ADDRESS 1331 E. Montg. Ave. Rockville, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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CERTIFICATE OF DEATH

11003

(M)

(1)

Thomas Brown, deceased, of the County of ... State of ...
born ... died ...
cause of death ...
attested and signed by the undersigned ...
this ... day of ... 19...

CHIEF OF BUREAU

10-2-01

10-2-01

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11664

11650

Item 9 Film 6297 10/20/61 ink

1. PLACE OF DEATH a. COUNTY <u>8007 Flower Ave. - Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY in 1b <u>years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>8007 Flower Avenue</u>				d. STREET ADDRESS <u>8007 - Flower Ave Takoma</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>A.</u> Last <u>RIFE</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>13</u> Year <u>1961</u>					
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov - 29 - 1875</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baker -</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cornelius Theodore Rife</u>				14. MOTHER'S MAIDEN NAME <u>Bertha H. Robert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Edna J. Giroux</u>		Address <u>8009 - Flower Ave Takoma Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Arteriosclerosis, Generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>10 yrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>13 Oct</u> 1961, that (I) (we) last saw the deceased alive on <u>13 Oct</u> 1961, and that death occurred at <u>445 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>M. B. Queen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>13 Oct 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>				22d. ADDRESS <u>7112 Willow Ave Takoma Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct-16-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Riggs Road Prince Georges Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				ADDRESS <u>254 Carroll St</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>	
				DATE <u>OCT 16 61</u>			

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MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11665
CERTIFICATE OF DEATH

11651

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) Florida b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pensacola	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 2005 North 8th Avenue	
3. NAME OF DECEASED (Type or print) First William Middle (None) Last Ross, Jr.		4. DATE OF DEATH Month October Day 18 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1948
9. AGE (In years last birthday) yrs. 13		IF UNDER 1 YEAR Months 7 Days 8 Hours X Min. -3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Florida
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Ross, Sr.	
14. MOTHER'S MAIDEN NAME Hattie M. Grier		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subacute glomerulonephritis DUE TO (b) Pulmonic Stenosis DUE TO (c) Hypergammaglobulinemia, marrow plasmocytosis CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Uremia Anemia Acidosis Hyperkalemia 13 months ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 17 September 1961 to 18 October, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 17 October, 1961 and that death occurred 1:40 AM from the causes and on the date stated above.			
22a. SIGNATURE Richard C. Adler		22b. DATE SIGNED 18 October 1961	
22c. PHYSICIAN'S NAME (Type) Richard C. Adler		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/61	
23c. NAME OF CEMETERY OR CREMATORY Pensacola		23d. LOCATION (City, town or county) (State) Florida	
24. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins		25a. REC'D BY REGISTRAR OCT 20 '61	
ADDRESS 4804 Lo... ..		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

VR A15 (4)
15M 9/60



Stomach

Bedroom

21 days

Penicillin

The Clinical Center, Bethesda 14, Md.

1000 North 8th Avenue

(Name)

William

Room, 12.

October 11, 1941

11

April 10, 1942

Neuro

also

None

Alcohol

Student

William Bone, Jr.

Attended N. Y. City

The Medical Record

None

The Clinical Center, Bethesda 14, Maryland

No

Acute lymphatic leukemia, chronic lymphatic leukemia

Chronic leukemia

Myelogenous leukemia, narrow chromatin

IV September 10, 1942

October 11

The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

John H. Hinkle

Chief, Hematology

Chief, Hematology

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11666

11652

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9411 Garwood Street				d. STREET ADDRESS 9411 Garwood Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EDITH Middle LOUISE Last ROWZEE				4. DATE OF DEATH Month 10 Day 20 Year 1961			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/8/1885	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Finance Office-- War Department				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward G. Rowzee				14. MOTHER'S MAIDEN NAME Estelle Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 578-32-3288			
17. INFORMANT Miss Blanche Rowzee				Address 9411 Garwood Street Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic DUE TO Vascular disease (c) Interval between onset and death 672 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from May 1961 to Oct 20 1961 , that (I) (we) last saw the deceased alive on 10/19 1961 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Bernard A. Fitzgerald				22b. DATE SIGNED 10/20/61			
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD				22d. ADDRESS 217 UNIV BLVD. S.E., Wash			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 10/23/61			
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery				23d. LOCATION (City, town, or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W.				25a. REC'D BY REGISTRAR OCT 23 '61			
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1156

CERTIFICATE OF DEATH

NAME

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Doctor

Signature of Registrar

Signature of Coroner

Signature of Witness

Handwritten notes and signatures in the lower section of the form.

10/11/11

James A. [illegible]

CORONER A. F. [illegible] on 11th Nov 11

1156

1156

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11667

11653

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
c. LENGTH OF STAY IN 1b 12 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 224 Falls Road		d. STREET ADDRESS 224 Falls Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Ryan		4. DATE OF DEATH Month Oct. Day 7, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1875
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 7 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Ft. Washington, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank Ward		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Son		Address John E. Ryan Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of right breast 170X DUE TO with generalized metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (no surgery) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 61 , to October 7 , 19 61 , that I last saw the deceased alive on Oct. 7 , 19 61 , and that death occurred at 10 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 110 S. Washington St. Rockville, Md. DATE SIGNED 10/7/61 ACTUAL SIGNATURE W. A. Linthicum M.D. PHYSICIAN'S NAME (Type) William A. Linthicum			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-61	
22c. NAME OF CEMETERY OR CREMATORY Darnestown Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR OCT 13 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

11668

11654

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>10 da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Sarber</u> Last <u>Sarber</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31, 1871</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hat finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Miller Hat Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Blander Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Sarber</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Darber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>201-07-6584</u>	
17. INFORMANT <u>Mrs. Florence Sindell</u>		Address <u>8523 Grubb Road Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>451x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aortic Aneurysm and Aortic Regurgitation</u> DUE TO <u>15 years</u> (c) <u>Atherosclerosis</u> years		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 1956</u> to <u>October 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 25, 1961</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert B. Havell MD</u>		22b. DATE SIGNED <u>10-31-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>		22d. ADDRESS <u>5576 Neb. Ave - DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/4/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sinking Springs, Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sinking Springs, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Nov 3 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		25c. ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>	

CERTIFICATE OF DEATH

1178

M

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 15, 1945*
5. Place of death: *New York City*
6. Cause of death: *Heart disease*
7. Signature of physician: *Dr. J. Smith*
8. Signature of registrar: *John Doe*
9. Date of registration: *Jan 16, 1945*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11669

11655

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Virginia		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Stafford		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital			d. STREET ADDRESS Highway #1		
3. NAME OF DECEASED (Type or print) James Michael Satkofsky			4. DATE OF DEATH Month Day Year October 10 1961		
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-22-48
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 12 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME Andrew Frank Satkofsky			14. MOTHER'S MAIDEN NAME Betty StClair		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Andrew Frank Satkofsky, Same as #2 above			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ewings Sarcoma DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State) 21. I certify that (this hospital) attended the deceased from Aug. 29, 1961 to Oct. 10, 1961, that (we) last saw the deceased alive on Oct. 10, 1961, and that death occurred at 5:50 AM, from the causes and on the date stated above. 22a. SIGNATURE J. AUG. DE WAAL M.D. 22b. DATE SIGNED Oct 10, 1961 22c. PHYSICIAN'S NAME (Type) JAN. C. DE WAAL, L.P.C. M.D. 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22f. DATE SIGNED Oct 10, 1961					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 13 Oct 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington		23e. (State) Va.		23f. DATE OCT 16 '61	
23g. REGISTRAR'S SIGNATURE Robert A. Pumphrey		23h. ADDRESS Funeral Home, Bethesda, Md.		23i. REGISTRAR'S SIGNATURE Arthur S. Huns	

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JAN 20 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
11670						11656								
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Key West (Naval Station)								
c. LENGTH OF STAY IN 1b 2 days						d. STREET ADDRESS Qtrs. R8								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Howpital, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Joy			First Webb			Middle SAUNDERS			4. DATE OF DEATH Month Oct. 27 Day 19 61					
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-2-61		9. AGE (In years last birthday) yrs. 2 Months 25		IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Key West, Florida				12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Walter E. SAUNDERS						14. MOTHER'S MAIDEN NAME Dorothy COOPER								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT (F) Walter E. SAUNDERS (same as #2 above)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congenital heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) mon globulin														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)			21. I certify that (this hospital) attended the deceased from 25 Oct., 1961, to 10-27-61, 1961 that (I) (we) last saw the deceased alive on 27 Oct., 1961, and that death occurred at 1125 PM on the causes and on the date stated above.											
22a. SIGNATURE Howard A. Pearson M.D.						ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) H.A. PEARSON LCDR MC USN						22b. DATE SIGNED 10-28-61								
22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10-31-61		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL				23d. LOCATION (City, town or county) ARLINGTON, VIRGINIA				
24. FUNERAL DIRECTOR'S SIGNATURE R.A. PUMPHREY						ADDRESS PUMPHREY FUNERAL HOME, BETHESDA, MARYLAND			25a. REC'D BY REGISTRAR DATE NOV 1 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Hume		

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CERTIFICATE OF DEATH

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U.S. Social Security Administration

DEATH

DATE

TIME

10-2-41

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U.S. Social Security Administration

U.S. Social Security Administration

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11671 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11657

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FOR STATE
HEALTH DEPT.

(M)

0799

(I)

VS. A15ME
SM 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>131 South Hampton Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Albert Carl Schneider</u>		4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 9, 1899</u>	9. AGE (In years last birthday) <u>61 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Johnstown, Pennsylvania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		14. MOTHER'S MAIDEN NAME <u>Frieda Veith</u>					
13. FATHER'S NAME <u>HENRY/Carl SCHNEIDER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or <u>unknown</u>) (If yes give year or dates of service) <u> </u>					
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>wife (spouse)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/11/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RICHLAND CEMETERY</u>			
22d. LOCATION (City, town, or country) <u>RICHLAND TOWNSHIP, PENNA.</u>		24a. REC'D BY REGISTRAR <u>DA OCT 10 '61</u>					
23. FUNERAL DIRECTOR <u>Joseph Gunkel</u>		ADDRESS <u>1756 PA. AVE., N.W., D.C. 6</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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RECEIVED BY THE DIRECTOR, FBI, WASHINGTON, D.C.

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VS. AISME
5M 9/60

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b Do A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hosp.		e. STREET ADDRESS 957 East West Hwy		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard (X M W N) Schuman		4. DATE OF DEATH 10 18 1961		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-25-99		9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 6 Days 1	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROGGER		12. KIND OF BUSINESS OR INDUSTRY Maryland		13. CITIZEN OF WHAT COUNTRY? USA.	
14. FATHER'S NAME Sam Schuman		15. MOTHER'S MAIDEN NAME Sarah - ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 097-05-1612		18. INFORMANT Mrs. Alice Schuman - wife		19. ADDRESS 10-18-61	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		23. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
25. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		26. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
28. (City or town)		29. (County)		30. (State)	
31. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		32. CHIEF MEDICAL EXAMINER Frank J. Broschank		33. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
34. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		35. DATE SIGNED 10-18-61		36. ADDRESS (Street, city, town, or county)	
37. ACTUAL SIGNATURE FRANK J. BROSHANK		38. M.D.		39. EXAMINER'S NAME (Type) FRANK J. BROSHANK	
40. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		41. DATE THEREOF 10-19-61		42. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN	
43. LOCATION (City, town, or country) FALLS CHURCH, VA		44. (State) VA		45. REC'D BY REGISTRAR OCT 20 '61	
46. REGISTRAR'S SIGNATURE Bernard Danzansky + Sons		47. ADDRESS 3501-14 1st NW		48. DATE OCT 20 '61	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11673

11659

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KENSINGTON GARDENS NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 10,300 BROOKMOOR DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JULIA WILHEMINA SEIM		4. DATE OF DEATH Month OCTOBER Day 8 Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 11, 1869
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE (retired)		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Klaus Wiesen		14. MOTHER'S MAIDEN NAME Julia Behlem	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MRS. FRANK W. SCHWEDHELM		Address 10,300 BROOKMOOR DRIVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) 493X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Cardiac weakness 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 59, 1961 to Oct 8, 1961 , that (I) (we) last saw the deceased alive on Oct 8, 1961 , and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE John N. Andrews 22c. PHYSICIAN'S NAME (Type) JOHN N. ANDREWS		22b. DATE SIGNED Oct. 9, 1961 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 9601 COLESVILLE ROAD, SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit	23b. DATE THEREOF 10/11/61	23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery	23d. LOCATION (City, town or county) Brooklyn, New York (State)
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR OCT 11 '61 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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John R. Lindbergh
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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11660

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmor Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3337 Reservoir Rd., N. W.</u> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) <u>ALICE</u> <u>KENNEDY</u> <u>SHALLBERG</u> First Middle Last			4. DATE OF DEATH <u>October 13</u> <u>1961</u> Month Day Year				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>April 16, 1875</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>— — — — —</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>Phillip Kennedy</u>				
14. MOTHER'S MAIDEN NAME <u>unknown</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>Mrs. W. H. Quealy</u> , Address <u>ml625 35th St, NW</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> (b) <u>Arteriosclerotic Cardiovascular disease</u> (c) <u>Sanitary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 12 1961</u> , 19 <u>58</u> to <u>Oct 12</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct 12 1961</u> , and that death occurred at <u>5:41-34th St NW</u> , M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J. A. Gannon Jr.</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. GANNON JR.</u>				22d. ADDRESS <u>5141-34th St NW</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-15-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>			
23d. LOCATION (City, town or county) <u>Moline,</u>		(State) <u>Illinois</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawyer's Sons,</u> ADDRESS <u>Washington, DC</u>				25a. REC'D BY REGISTRAR <u>OCT 16 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles L. Hanna</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11675											
11661											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN lb Marilea Nursing Home 14511 Colesville Road d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14511 Colesville Road						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 301 Baltimore Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Roger			5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF DEATH October 2 19 61			9. AGE (In years last birthday) 85 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			11. BIRTHPLACE (County & State, or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME George Shaw			14. MOTHER'S MAIDEN NAME Artie Garrett			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes-Spanish American		
16. SOCIAL SECURITY NO. None			17. INFORMANT Catherine Bride-Daughter-same 2d			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 332X (b) Cerebral Thrombosis (c) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 12 hrs 24 hrs Indefinite		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Trophic ulcer of leg											
22a. SIGNATURE Stephen N. Jones 22c. PHYSICIAN'S NAME (Type) STEPHEN N. JONES			22b. DATE THEREOF 10/4/61			22d. ADDRESS Rockville Cemetery Rockville, Maryland			22e. REC'D BY REGISTRAR OCT 4 '61		
22f. (City or town) Rockville			22g. (County) Maryland			22h. (State) Maryland			22i. DATE SIGNED 10/2/61		
22j. SIGNATURE Robert A. Pumphrey			22k. DATE THEREOF 10/4/61			22l. ADDRESS Bethesda, Maryland			22m. SIGNATURE Arthur S. House		

VR A15 (4)
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11373

Montgomery

Silver Spring

Marilee Nursing Home
1401 Colverville Road

Robert

Male White

x

Gov't

Retired

George Shaw

Yes-Spanish American None

Maryland

Rockville

301 Baltimore Road

October 2

Sept. 17, 1878 85

Maryland

Little Garrett

Catharine Bixbe-Bugher-son 25

THOMAS H. JONES

Rockville, Maryland

Burial 10/4/01 Rockville Cemetery

Rockville, Maryland

Robert A. Humphrey, Bethesda, Maryland Oct 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
11676																			
11662																			
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					d. STREET ADDRESS 6110 54th Ave.														
3. NAME OF DECEASED (Type or print) Maude Violet Sibert					4. DATE OF DEATH October 3 19 61														
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 23, 1885		9. AGE (In years last birthday) yrs. 76											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? USA												
13. FATHER'S NAME Albert Barton					14. MOTHER'S MAIDEN NAME Nancy Fisher														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No					16. SOCIAL SECURITY NO. Unknown					17. INFORMANT Hospital Records									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Anaplastic Carcinoma (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)					20g. (County)					20h. (State)									
21. I certify that (this hospital) attended the deceased from April 19, 1961, to October 3, 1961, that (we) last saw the deceased alive on October 3, 1961, and that death occurred at 4:20 PM from the causes and on the date stated above.										22a. SIGNATURE William F. Warrender M.D.					22b. DATE SIGNED October 4, 1961				
22c. PHYSICIAN'S NAME (Type) WILLIAM F. WARRENDER, LT MC USN										22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Oct. 6, 1961					23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery									
23d. LOCATION (City, town or county) Arlington, Virginia					23e. (State)														
24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS, Riverdale, Md.										25a. REC'D BY REGISTRAR DATE OCT 9 '61					25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN b Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 310 Lincoln Ave												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 310 Lincoln Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Emily Marie Sikorra						4. DATE OF DEATH Oct 6 1961																	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/9/1889		9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Minn.				12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Chris Behnken						14. MOTHER'S MAIDEN NAME Marie Lewig																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Emily Hida (daughter)				Address Item 2													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous coronary disease INTERVAL BETWEEN ONSET AND DEATH Sudden																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Prince Geo. Co.		(County) Maryland		(State)													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/7/61 DATE SIGNED Address (Street, city, town, or county)																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9, 1961		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or country) Prince Geo. Co. Maryland		(State)															
23. FUNERAL DIRECTOR J. Arthur Walters, 254 Carroll St NW DC.				24a. REC'D BY REGISTRAR OCT 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines																	

M

P

Vertical text on the right margin

A large handwritten note at the bottom of the page, possibly a signature or a date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11678		11664	
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 2 1/2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 7301 Piney Branch Rd., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First J. Middle Bond Last Smith		4. DATE OF DEATH Month October Day 20 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/90
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 01 Days 01 Hours 01 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Benjamin F. Smith		14. MOTHER'S MAIDEN NAME Emma Bond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-38-3675	
17. INFORMANT Wife. Same as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL Hemorrhage 237x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) LEFT Frontoparietal Brain Tumor ? DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 24h	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from Jan 19 55 to Oct 20 1961 , that (I) (we) last saw the deceased alive on Oct 19 1961 , and that death occurred at 8:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Merrill M. Cross		22b. DATE SIGNED 10/20/61	
22c. PHYSICIAN'S NAME (Type) MERRILL M. C. CROSS		22d. ADDRESS 8248 Georgia ave Silver Spring Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/61	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) Washington D.C. (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumfrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25a. REC'D BY REGISTRAR OCT 24 '61 25b. REGISTRAR'S SIGNATURE S. H. HARRIS	

11078

CERTIFICATE OF DEATH

1

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 11679 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11665

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY in 1b D.O.A d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 13917 BAUER DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY REED SMITH a. SEX Female b. COLOR OR RACE White c. MARIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> d. DATE OF BIRTH May 13, 1888 e. AGE (In years last birthday) 73 yrs. f. IF UNDER 1 YEAR: Months 0 Days 0 g. IF UNDER 24 HRS.: Hours 0 Min. 0		4. DATE OF DEATH OCT. 8 61 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Daniel Hogue 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) 16. SOCIAL SECURITY NO. no 17. INFORMANT Son-in Law Address Same as above.		14. MOTHER'S MAIDEN NAME Chaseldine, Clara 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) 420/ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous coronary disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 19 Hour p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Frank J. Brochart EXAMINER'S NAME (Type) Frank J. Brochart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10-9-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 10/11/61		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery 22d. LOCATION (City, town, or country) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR The S.H. Hines Company ADDRESS 2901 14th St. Washington 9, D.C.		24e. REC'D BY REGISTRAR OCT 11 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kane	

M

THE H. H. BROWN COMPANY
1001 N. 1st St. St. Paul, Minn.
1911

11680 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11666

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4315 Chestnut st</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4315 Chestnut st</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Chetchee</u> Middle <u>Spaulding</u> Last <u>John H.</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>3</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-16-40</u>			
9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Garrett V. Graves</u>				14. MOTHER'S MAIDEN NAME <u>Suzanne Gillespie</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>John H. Spaulding - Sister</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Unknown</u> DUE TO <u>795.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>795.3</u> DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was found collapsed in living room of her home 10-3-61</u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschatt</u> M.D.				CHIEF-MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschatt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				Address (Street, city, town, or county) <u>10-3-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/4/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) <u>Suitland, Maryland</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>Oct 6 '61</u>					
				24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>					



88

Robert A. Simpson, Secretary, Maryland
State Bill Committee, Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11667

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10620 GEORGIA AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle - Last SPECTOR		4. DATE OF DEATH Month 10 Day 22 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 1886
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR: Months 10 Days 22 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MOSES WEISER		14. MOTHER'S MAIDEN NAME ESTHER KOSVEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MOZART ISPECTOR		Address 13412 DAUPHINE ST	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary atherosclerosis DUE TO (c) 2 yrs INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/5 , 19 58 , to 10/22 , 61 , that I last saw the deceased alive on 10/22 , 61 , and that death occurred at 3:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald Nelson		ADDRESS (Street, city or town, state) 10620 Georgia Ave, Silver Spring, Md.	
DATE SIGNED 10/24/61			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/24/61	
22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. CEM.		22d. LOCATION (City, town, or county) (State) HYATTSVILLE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Soldner Funeral Home		ADDRESS 4217-9th St NW	
24a. REC'D BY REGISTRAR OCT 25 61		DATE	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

11681

(M)

NAME OF DECEASED
M.D.
SEX
AGE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN

DATE OF REPORT
PLACE OF REPORT
NAME OF REPORTER
SIGNATURE OF REPORTER
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN

DATE OF REPORT
PLACE OF REPORT
NAME OF REPORTER
SIGNATURE OF REPORTER
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11682

11668

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in lb <u>2 1/2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> D.C. b. COUNTY <u>Mont.</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>Washington</u> d. STREET ADDRESS <u>4801 Conn. Ave. N.W.</u> <u>Dpt. 609</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Anna Mae</u> Middle <u>Stanton</u> Last <u>Stanton</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1961</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <u>10/28/84</u>		9. AGE (In years last birthday) <u>76</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months	Days								
Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dist. of Co.</u>					
11. BIRTHPLACE (County, state, or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Walter Morrison</u>				14. MOTHER'S MAIDEN NAME <u>?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>					
17. INFORMANT <u>Alvin L. Aubinoe</u> Address <u>1500 Overhill Rd. Bethesda, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Cecum</u> (b) <u>ISB.D</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. <u>8:10</u> p.m. <u>10-14</u> Year <u>1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1959</u> to <u>October 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>October 14, 1961</u> , and that death occurred at <u>5:10 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Michael J. McInerney M.D.</u>				22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>1150 - CONN Avenue D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-17-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>					
23d. LOCATION (City, town or county) <u>WASHINGTON, DC</u>		(State)							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudin's Sons, 1756 12th Ave. NW</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 17 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11683

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11670

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>D.O.A.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1213 East Chase Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Archie</u> First Middle Last 4. DATE OF DEATH <u>Oct. 23 1961</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-12-19</u> 42 yrs. 9. AGE (In years last birthday) <u>42</u> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Ligon & Ligon</u> 11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Caesar Stuckey</u> 14. MOTHER'S MAIDEN NAME <u>Bella Genther</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>2249-42-1144</u> 17. INFORMANT <u>Same</u> Address <u>As above</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Insufficiency</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Sudden</u> DUE TO <u>unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-24-61</u> Address (Street, city, town, or county)							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>10-26-61</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State) <u>FLORENCE, S.C.</u>	
23. FUNERAL DIRECTOR <u>M.E. ELLIKSON - 1129 N. CAROLINE ST.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>OCT 26 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinney</u>	

11082

STATE OF
NEW YORK

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10-11-61

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 16 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 5014 Sheridan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD WARREN STUNKLE		4. DATE OF DEATH Month October Day 20, Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1908
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 53	11. IF UNDER 24 HRS. Hours 53
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Clerk		12b. KIND OF BUSINESS OR INDUSTRY Government	
13. FATHER'S NAME Lindsey Stunkle		14. MOTHER'S MAIDEN NAME Margaret Lilly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record		18. ADDRESS The Clinical Center, Bethesda 14, Maryland	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia with a gram negative organism 204.3 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Hepatic Failure DUE TO (c) Acute Myelogenous leukemia DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 1 Day 2 Days 2 Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 4, 1961 to October 20, 1961 , that (I) (we) last saw the deceased alive on Oct. 20, 1961 , and that death occurred 1:00PM , from the causes and on the date stated above.			
22a. SIGNATURE Carl J. Bentzel M.D.		22b. DATE SIGNED 10-21-61	
22c. PHYSICIAN'S NAME (Type) Carl J. Bentzel M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/61	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland		25a. REC'D BY REGISTRAR DACT 24 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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1188

Montgomery Jefferson 12 days 2001 Sheridan Street

White Government Clerk Lindsay Stunkle

February 2, 1908 Maryland

Not available The Clinical Center, Bethesda, Md., Maryland

1 day 2 days 3 days

acute poliomyelitis

October 10, 1908

October 10, 1908

October 10, 1908

October 10, 1908

October 10, 1908

October 10, 1908

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October 10, 1908

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October 10, 1908

October 10, 1908

October 10, 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11685

11672

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 40 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE California b. COUNTY San Francisco c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 2150 33rd Avenue d. STREET ADDRESS 43X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE HELEN SULLIVAN		4. DATE OF DEATH Month October Day 9 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 9, 1905 55 yrs.
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 4 Days 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Co. Executive		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (County & State, or foreign country) California		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Joseph Pyne		14. MOTHER'S MAIDEN NAME Mary Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 558-09-1430	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adrenalcortical tumor DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 4 Days DUE TO (c) 6 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 30, 19 61 to October 9, 19 61 that (I) (we) last saw the deceased alive on October 9, 19 61, and that death occurred at 7:30AM from the causes and on the date stated above.			
22a. SIGNATURE J. David Heywood J. David Heywood M.D.		22b. DATE SIGNED 10-9-61	
22c. PHYSICIAN'S NAME (Type) J. David Heywood M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 10/10/61		23b. DATE THEREOF 10/10/61	
23c. NAME OF CEMETERY OR CREMATORY Golden Gate Cemetery		23d. LOCATION (City, town or county) (State) San Bruno, California	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR OCT 13 '61	
25b. REGISTRAR'S SIGNATURE William S. Kraus			

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San Francisco

San Francisco

The Clinical Center

ALICE

BELLY

WILLIAM

October 2, 1902

October 2, 1902

Female White

Insurance Co. Executive Insurance

California

John Joseph Lynn

John Joseph Lynn

The Federal Record

52-50-120 The Clinical Center, Bethesda, Maryland

The Clinical Center, Bethesda, Maryland

Insurance

October 2, 1902

October 2, 1902

J. P. Smith

The Clinical Center, Bethesda, Maryland
Institute of Health, Bethesda, Md.

San Francisco 10/10/02 Golden Gate Cemetery San Bruno, California

Robert A. Humphrey, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11673

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase Village</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase Village.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5510 Grove St.</u>		d. STREET ADDRESS <u>5510 Grove St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Grover</u> Middle <u>L.</u> Last <u>Swink</u>		4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert L. Swink</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Webster.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Anna Swink (wife)</u>		Address <u>5510 Grove St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis.</u> DUE TO (c) <u>Generalized Arteriosclerosis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 months.</u> <u>3 1/2 months.</u> <u>20 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 15, 1961</u> to <u>Oct. 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 27, 1961</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles W. Humphreys Jr.</u> M.D.		22b. DATE SIGNED <u>Oct. 31 '61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Humphreys Jr.</u>		22d. ADDRESS <u>917 20th St. N.W. Washington DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/31/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Oct 31 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. DATE <u>Oct 31 '61</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11687

11674

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE D.C. b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bel Pre Nursing & Convalescent Home 2601 Bel Pre Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. NAME OF DECEASED (Type or print) GERTRUDE NICKELL		4. DATE OF DEATH Month Oct Day 28 Year 1961	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/28/1873	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 28 Hours 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME --- Nickell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Manning Dyer		Address 5033 Loughboro Rd. N.W. Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Arteriosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic Heart Disease & Congestive Failure		INTERVAL BETWEEN ONSET AND DEATH 1 day - 4 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (His hospital) attended the deceased from Nov 27 1961 to Oct 28 1961 , that (I) (we) last saw the deceased alive on Oct 28 1961 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Neil P. Campbell		22b. DATE SIGNED 10/28/61	
22c. PHYSICIAN'S NAME (Type) Neil P. Campbell		22d. ADDRESS Kenesaw Apt	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/61	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		25a. REC'D BY REGISTRAR NOV 1 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		25c. REGISTRAR'S SIGNATURE Arthur S. Hines	

M

11883

11883

D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11675

11688

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 657, Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LE DEAU GARDENS		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ALICE MAE THOMPSON		4. DATE OF DEATH Month Day Year Oct. 28 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27-1876
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Page		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records, Nursing Home		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema, Cardiac Asthma DUE TO (c) Arterio sclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1959 , 19____, to Oct 27 , 19 61 , that I last saw the deceased alive on Oct 27 , 19 61 , and that death occurred at 7:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord St., Kensington, Md. DATE SIGNED 10/28/61			
ACTUAL SIGNATURE Robert T. Thibadeau M.D.			
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/61	
22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) Clarksburg, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Helton		ADDRESS Barnesville, Md	
24a. REC'D BY REGISTRAR DATE NOV 1 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

CERTIFICATE OF DEATH

1987



NAME OF DECEASED: James Earl
AGE: 35 YEARS
SEX: Male
RACE: White

DATE OF DEATH: July 1, 1987
PLACE OF DEATH: Home

DATE OF BIRTH: Oct. 27-1951

PLACE OF BIRTH: Baltimore

CAUSE OF DEATH: Unknown

HOSPITAL RECORDS: None

Classified by: 1

Revised by: 1

Signature: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11689

CERTIFICATE OF DEATH

11676

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
f. STREET ADDRESS 3918 Wilson Blvd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Eugene Last Thompson		4. DATE OF DEATH Month October Day 2 Year 1961	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 30, 1961
9. AGE (In years last birthday) yrs. 0 Months 2 Days 2		IF UNDER 1 YEAR Hours 2 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Bethesda, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack E. Thompson		14. MOTHER'S MAIDEN NAME Janice C. Bice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Jack E. Thompson, Same as #2 above	
17. INFORMANT Jack E. Thompson, Same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac & Respiratory Arrest DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 433.0 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 30, 1961 , to Oct. 2, 1961 , that XII (we) last saw the deceased alive on Oct. 2, 1961 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Frederic Schulaner M.D.		22b. DATE SIGNED 2 Oct 1961	
22c. PHYSICIAN'S NAME (Type) FREDERIC SCHULANER, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Shipment		23b. DATE THEREOF 3 Oct 1961	
23c. NAME OF CEMETERY OR CREMATORY Beverly Hills Memorial Gardens		23d. LOCATION (City, town or county) (State) Morgantown W.Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		25a. REC'D BY REGISTRAR OCT 4 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kenna		25c. DATE OCT 4 '61	

M

11088

STATE OF NEW YORK

11088

IN SENATE, January 11, 1907.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE.

ALBANY: JAMES B. LEECH, STATE PRINTER, 1907.

THE COMMISSIONERS OF THE LAND OFFICE HAVE THE HONOR TO ACKNOWLEDGE THE RECEIPT OF THE FOLLOWING:

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11690 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12304

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Ind</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Rockville</u>			
c. LENGTH OF STAY IN 1b <u>life</u>				d. STREET ADDRESS <u>Harris Farm - Falls Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Leuman</u>		First <u>Leuman</u> Middle <u>Lynn</u> Last <u>Trent</u>		4. DATE OF DEATH <u>Oct 31 1961</u>		Month <u>Oct</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 4 - 1961</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR <u>2</u> Months <u>27</u> Days		IF UNDER 24 HRS. <u>2</u> Hours <u>27</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Mo</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Samuel Trent</u>				14. MOTHER'S MAIDEN NAME <u>Betty Knight</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Betty Trent (mother)</u>				Address <u>Illum 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Respiratory Infection</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 med dead in bed</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschek</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschek</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>10-31-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 1 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		22d. LOCATION (City, town, or country) (State) <u>Laytonsville Md.</u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md</u>				24a. REC'D BY REGISTRAR <u>NOV 8 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(M)

Nov. 1 1951 Daytonville

Daytonville, Mo

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11691

11677

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rt. #2 Gaithersburg d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN THOMAS TRIGGER		4. DATE OF DEATH Month 10 - Day 3 Year 19 61	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-85
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) janitor		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Trigger		14. MOTHER'S MAIDEN NAME Belle Trigger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 214-18-8604	
17. INFORMANT hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomposition 434.4 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Terminal Pneumonia (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January, 1961, to 10-3, 1961 , that (I) (we) last saw the deceased alive on 10-3, 1961 , and that death occurred at 5:22 P.M. from the causes and on the date stated above.			
22a. SIGNATURE L. I. Leal		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. I. Leal, M.D.		22d. ADDRESS Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-6-61	
23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City, town or county) (State) Montgomery, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR DACT 9 '61	
ADDRESS Laytons ville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
11692					11678				
1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE DISTRICT OF COLUMBIA				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA, MARYLAND (Rural)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON, D. C.				
c. LENGTH OF STAY IN 1b Minutes					d. STREET ADDRESS 3604 18th STREET, NORTH EAST				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. NAVAL HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN HENRY TYLER					4. DATE OF DEATH OCTOBER 11 19 61				
5. SEX MALE					6. COLOR OR RACE NEGROID				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH JULY 23, 1910				
9. AGE (In years last birthday) 51 yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOOD PREPARATION					10b. KIND OF BUSINESS OR INDUSTRY CIVILIAN EMPLOYEE				
11. BIRTHPLACE (County & State, or foreign country) SOUTH CAROLINA					12. CITIZEN OF WHAT COUNTRY? UNITED STATES				
13. FATHER'S NAME NELSON TYLER					14. MOTHER'S MAIDEN NAME Gora Lee				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO					16. SOCIAL SECURITY NO. 579/01/7000				
17. INFORMANT ELIZABETH ESSIE TYLER (WIFE)					Address 3604 18th STREET N. E. WASH., D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct 11 1961 to Oct 11 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct 11 1961, and that death occurred at 7:15 PM from the causes and on the date stated above.					22b. DATE SIGNED 12 Oct 1961				
22a. SIGNATURE D. L. Kettering					22c. PHYSICIAN'S NAME (Type) D. L. KETTERING, LT MC USN				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 16 Oct 1961				
23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Cemetery					23d. LOCATION (City, town or county) (State) Washington D. C.				
24. FUNERAL DIRECTOR'S SIGNATURE JOHNSON AND JENKINS					25a. REC'D BY REGISTRAR DATE OCT 16 '61				
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas									

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My dear Mr. [illegible]
[illegible]

[illegible signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11694 CERTIFICATE OF DEATH 11680											
1. PLACE OF DEATH a. COUNTY Montg MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown						c. LENGTH OF STAY IN 1b 13 yrs					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) At Home.						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) Marjorie Minnie Unglesbee						4. DATE OF DEATH Month Oct Day 31 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21-1890		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 4 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Adamstown Md.				12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles H. Grimes						14. MOTHER'S MAIDEN NAME May Schaeffer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If you give war or date of service)		17. INFORMANT Harry W. Unglesbee Address As #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertension DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 11, 1958 to Oct 31, 1961 , that (I) (we) last saw the deceased alive on Oct 31, 1961 , and that death occurred at 11:45 p.m. from the causes and on the date stated above.											
22a. SIGNATURE Vernon E. Martens M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov. 1-61			
22c. PHYSICIAN'S NAME (Type) Vernon E. Martens						22d. ADDRESS Germantown. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11-3-61		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet		23d. LOCATION (City, town or county) (State) Frederick Md.			
24 FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. ADDRESS Gaithersburg. Md.						25a. REC'D BY REGISTRAR NOV 3 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

VR A15 (4)
15M 9/60

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FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/6D

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11661

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>12 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7723 Eastern Ave., APT. 24</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>7723 Eastern Ave - Apt 24</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>Mary Bertha Urban</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>3</u> Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OF SKIN <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-8-1900</u>		9. AGE (in years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE STORE</u>				11. BIRTHPLACE (State or foreign country) <u>Poland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Andrew Farneski</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-14-1663</u>				17. INFORMANT <u>Victoria Patrode (daughter)</u> Address <u>Stem 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>																INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-3-61</u> Address (Street, city, town, or county)																					
ACTUAL SIGNATURE <u>Frank J. Bluschant</u>				M.D. <u>FRANK J. BLUSCHANT</u>				NAME (Type) <u>FRANK J. BLUSCHANT</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/5/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR <u>Raymond A Ziska</u>				ADDRESS <u>8434 Georgia Avenue</u>				24a. REC'D BY REGISTRAR <u>OCT 5 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>									
Warner E. Pumphrey, Inc.				Silver Spring, Maryland																	

1893

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11696

11682

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>German town - R-2</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>54 Chevy chase</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>4116 Aspen st</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>md R-118</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Oscar Paul Vogel</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-95</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>atly U.S. Government - Rev.</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Vogel</u>	
14. MOTHER'S MAIDEN NAME <u>Katherine Fessler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Anne Vogel (wife)</u> Address <u>Ind R</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 973.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon-monoxide poisoning</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in auto</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hose attached to exhaust entering in auto</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-12-1961</u> Hour a.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>md R-118</u>		20f. City or town <u>in German town montg md</u>	
20g. County <u> </u>		20h. State <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/14/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR ADDRESS <u>The S.H.Hines Company-2901 14th St., N.W.</u>		24a. REC'D BY REGISTRAR <u>OCT 16 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		DATE <u> </u>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11697

11683

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Swannanoa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swannanoa</u>	
c. LENGTH OF STAY IN TB <u>49 days</u>		d. STREET ADDRESS <u>Rt. 1, Box 261</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frederick Volbeda</u>		4. DATE OF DEATH <u>October 10 19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 12, 1907</u>	
9. AGE (In years last birthday) <u>54-3</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Naval Officer (Chaplain)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Volbeda</u>		14. MOTHER'S MAIDEN NAME <u>Alice Groendyck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW II & Korea</u>		16. SOCIAL SECURITY NO. <u>246-58-1983</u>	
17. INFORMANT <u>WIFE: Mrs. Catherine C. Volbedia, Same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Chronic Lymphatic Leukemia</u> 204-0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Autoimmune Hemolytic Anemia</u> <u>Multiple Pulmonary Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 23, 1961</u> to <u>October 10, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 10, 1961</u> , and that death occurred at <u>3:12AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John M. Lewis</u> M.D.		22b. DATE SIGNED <u>10 October 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. LEWIS LCDR MC USN</u>		22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Shipment 10-10-61</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Swannanoa, North Carolina</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>OCT 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		25c. ADDRESS <u>Bethesda, Md.</u>	
25d. DATE <u>OCT 13 '61</u>		25e. ADDRESS <u>7557 Wisconsin Ave.,</u>	

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U. S. Naval Hospital

San Francisco (Calif.)

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11698

Item 2 Film G298 10/27/61 iwk

CERTIFICATE OF DEATH

11684

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MD Wash. D.C. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville <i>Route #29</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville Washington, D.C. <i>47X-3</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Belmont Nursing Home				d. STREET ADDRESS 701 - 9th. St. N.E. 17220 1/2 Colesville Rd.			
3. NAME OF DECEASED (Type or print) Catherine Kane Wahl				4. DATE OF DEATH October 20th. 1961.			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 14, 1869	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Geier			
14. MOTHER'S MAIDEN NAME unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO (b) Gen'ralized arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 yr 5-10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1, 1961 to 10/20/1961 , that (I) (we) last saw the deceased alive on 10/17/1961 , and that death occurred at 12:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Donald Nelson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/22/61	
22c. PHYSICIAN'S NAME (Type) Donald Nelson				22d. ADDRESS 10620 Ga. Ave Sil Sp., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-21-61		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet		23d. LOCATION (City, town or county) (State) Washington D.C.	
24 FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.				25a. REC'D BY REGISTRAR OCT 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
11699													
11685													
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 63 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 8515 Greenwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LAURA ANN WARE						4. DATE OF DEATH Month Day Year October 9, 19 61							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 24, 1958		9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Hercell O. Ware						14. MOTHER'S MAIDEN NAME Judith Ann Labofish							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. None						17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Lymphocytic Leukemia with splenomegaly and hepatomegaly (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 Days 5 months										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) August 7, 19 61		(County) October 9, 19 61			
(State) Ar. Geo. Co., Md.													
21. I certify that (I) (this hospital) attended the deceased from August 7, 19 61 to October 9, 19 61 , that (I) (we) last saw the deceased alive on October 9, 19 61 , and that death occurred at 7:50 a.m. from the causes and on the date stated above.													
22a. SIGNATURE J. David Heywood M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 10/10/61				
22c. PHYSICIAN'S NAME (Type) J. DAVID HEYWOOD, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/61		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Mem.				23d. LOCATION (City, town or county) Ar. Geo. Co., Md.					
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc.						ADDRESS 1400 Chapin St. N.W., Wash., D.C.		25a. REC'D BY REGISTRAR October 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11700

11686

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 5 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 9909 Thornwood Rd., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter P Warendorff		4. DATE OF DEATH Month October Day 31 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1904
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 7 Days 1 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Victor Warendorff		14. MOTHER'S MAIDEN NAME Clare Karge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) Navy WW II		16. SOCIAL SECURITY NO. Helen (wife)	
17. INFORMANT same as above		Address same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus (Metastasis (Generalized) (operated July 1960) DUE TO (b) 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1 yr. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 yr.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19 1958 to 10/31/61 , 19 58 , that (I) (we) last saw the deceased alive on 10/31/61 , 19 58 , and that death occurred on 10/31/61 from the causes and on the date stated above.			
22a. SIGNATURE Sam Allen		22b. DATE SIGNED 10-31-61	
22c. PHYSICIAN'S NAME (Type) SAMUEL ALLEN		22d. ADDRESS Kensington, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-3-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR NOV 3 '61	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VR A15 (4)
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11687

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C.		b. COUNTY Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Middle Last (Jr.) Samuel McKinley Warren		4. DATE OF DEATH Month Day Year October 29 1961		5. SEX Male	
6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1926		9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY State Dept.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME S amuel McKinley Warren, Sr.	
14. MOTHER'S MAIDEN NAME Mary Catherine Garvett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes L944-46		16. SOCIAL SECURITY NO. L944-46		17. INFORMANT (Brother) James A. Warren		Address Seven Locks Road, Cabin John Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral laceration + hemorrhage 982X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) penetrating wound of skull by ax DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Laceration of left arm		INTERVAL BETWEEN ONSET AND DEATH Sudden		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18). struck with an ax		20c. TIME OF INJURY Month, Day, Year 2:52 PM 10-29-61	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) accused home		20f. (City or town) Bethesda		(County) monty		(State) md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Frank J. Broschart		M.D. EXAMINER'S NAME (Type) FRANK J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-29-61		Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/2/61	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.		22d. LOCATION (City, town, or country) Arlington, Va.		(State)		23. FUNERAL DIRECTOR John T. Chaworth		ADDRESS 3015-12th St E	
24a. REC'D BY REGISTRAR NOV 1 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE		25. REC'D BY REGISTRAR NOV 1 '61		25b. REGISTRAR'S SIGNATURE	

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TO RITUAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11702 CERTIFICATE OF DEATH 11688											
1. PLACE OF DEATH a. COUNTY Montg b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg c. LENGTH OF STAY IN 1b 07 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montg, Co. Gen Hosp. D OA						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 2 James Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Addie Middle Belle Last Watkins						4. DATE OF DEATH Month Oct Day 12th Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 25-1898		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 11 Days 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Home Work				11. BIRTHPLACE (County & State, or foreign country) Montgomery Co.		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME James B. Hawkins						14. MOTHER'S MAIDEN NAME Annie Belle Burns					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Clayton K. Watkins. Gaithersburg, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 day											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-12 , 19 61 , to 10-12 , 19 61 , that (I) (we) last saw the deceased alive on 10-12 , 19 61 , and that death occurred at 9:20 PM , from the causes and on the date stated above.											
22a. SIGNATURE F.J. Broschart M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) F.J. Broschart						22d. ADDRESS 4 Russell Ave - Gaithersburg Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10-14-61		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town or county) (State) Gaithersburg. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner ADDRESS Gaithersburg. Md.						25a. REC'D BY REGISTRAR Oct 16 '61 DATE		25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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11703
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11689

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>3 MOS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>354015 Adams Dr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				d. STREET ADDRESS <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Susannah</u> Middle <u>L.</u> Last <u>Wickham</u>				4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19, 1886</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Wheeling, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Stamm</u>				14. MOTHER'S MAIDEN NAME <u>Honora O'Malley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Charles B. Heineman 4015 Adams Drive Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis (Left Side)</u> 332X DUE TO <u>Arteriosclerosis - generalized (age 75)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Sexility due to alcohol</u> (b) <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>yr</u> <u>yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/7/61</u> 19 to <u>10/4/61</u> 19, that (I) (we) lost saw the deceased alive on <u>2/2/61</u> 19, and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>SAM ALLEN</u> SAM ALLEN, M.D. Kensington, Maryland				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>SAM ALLEN</u>	
22d. ADDRESS <u>10,407 Fawcett Street, Kensington Maryland</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Ziska</u> ADDRESS <u>8434 Georgia Avenue</u>				25a. REC'D BY REGISTRAR <u>Oct 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
Warner E. Pumphrey, Inc. Silver Spring, Maryland				DATE			

STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1903

(M)

County of San Diego State of California
I, John W. Smith, Registrar of the County of San Diego, State of California, do hereby certify that on the 10th day of April, 1903, at the City of San Diego, State of California, died John W. Smith, a male, of the County of San Diego, State of California, aged 45 years, the cause of death being Heart Disease, the result of Longevity.

(1)

Witness my hand and the seal of said County at the City of San Diego, State of California, this 10th day of April, 1903.

John W. Smith
Registrar of the County of San Diego, State of California

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11704

CERTIFICATE OF DEATH

11690
11690
10/16/61 ink

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL		d. STREET ADDRESS 1819 G STREET NW	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA Middle WILLIAMS Last WILLIAMS		4. DATE OF DEATH Month OCT Day 8 Year 1961	
5. SEX F	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 JAN 1874
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BROOKLYN N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME GEO. L. A. MARTIN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NOVE	
17. INFORMANT HUSBAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO ESSENTIAL HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS (c) SENILITY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY 1, 1944 to OCT. 8, 1961 , that (I) (we) last saw the deceased alive on OCT. 8, 1961 , and that death occurred at 6:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Joseph G. Lawrence		22b. DATE SIGNED 10/9/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 5206 Norway Dr. Chevy Chase, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10/9/61	
23c. NAME OF CEMETERY OR CREMATORY Wash. D.C. 17-56		23d. LOCATION (City, town, or county) (State) Newark, N.J.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Lawrence		25a. REC'D BY REGISTRAR DATE OCT 11 '61	
ADDRESS 17-56		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

11504

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11705

CERTIFICATE OF DEATH

Item 9 Film G297 10/16/61 iwk

11691

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN b 7 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1706 Republic Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) clarence Eugene Wilson			4. DATE OF DEATH Month 10 Day 8 Year 1961		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/30/79	9. AGE (In years last birthday) 81 1/2	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Wilson			
14. MOTHER'S MAIDEN NAME Anna Baggett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes Spanish-American			
16. SOCIAL SECURITY NO. 577-18-2223		17. INFORMANT Eugene Austin Wilson			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 6000 DUE TO Conditions, if any, which gave rise to immediate cause (b) CHRONIC PYELONEPHRITIS (c) 12 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CARDIAC ARRHYTHMIA (VENTRICULAR TACHYCARDIA)		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, if fatal on Part I of report)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10/29/61	
20f. (City or town) 10/8/61		20g. (County) Prince George's County, Md.		20h. (State) Md.	
21. I certify that (I) (This hospital) attended the deceased from 10/29/61 to 10/8/61 , 19 1961 , that (I) do saw the deceased alive on 10/7/61 , and that death occurred 2:05 AM from the causes and on the date stated above.					
22a. SIGNATURE John P. Martin M.D.		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/8/61	
22d. PHYSICIAN'S NAME (Type) JOHN P. MARTIN, M.D.		22e. ADDRESS John P. Martin Sandy Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
23d. LOCATION (City, town or county) Prince George's County, Md.		23e. REC'D BY REGISTRAR OCT 10 '61			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Z. 230		24b. ADDRESS 8434 Georgia Avenue		24c. REGISTRAR'S SIGNATURE Arthur L. Hines	
24d. REGISTRAR'S NAME Warner E. Pumphrey, Inc.		24e. ADDRESS Silver Spring, Maryland			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11706

11692

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>Rockbridge</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>4 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>700 Hudson Avenue</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lexington</i>	
3. NAME OF DECEASED (Type or print) First <i>ELIZABETH</i> Middle <i>GEORGE</i> Last <i>WILSON</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>24</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 9, 1881</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James George</i>		14. MOTHER'S MAIDEN NAME <i>Ida Parr</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. R.F. Steidtmann</i>		Address <i>Providence House 190-55 New York - N.Y.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary artery occlusion</i> (c) <i>Coronary arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i> <i>10 minutes</i> <i>3 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> 1957 to <i>Oct 24</i> 1961, that (I) (we) last saw the deceased alive on <i>Oct 20</i> 1961, and that death occurred at <i>7:30 A</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Samuel T. Kimble</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>S. T. KIMBLE</i>		22d. ADDRESS <i>927 Pershing Dr., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Oct 28, 1961</i>	<i>New Providence Cemetery</i>	<i>Lexington, Virginia</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters, 254 Carroll St NW D.C.</i>		25a. REC'D BY REGISTRAR <i>OCT 27 '61</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

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CERTIFICATE OF DEATH

Reg. Dist. No. 1693

1. PLACE OF DEATH o. COUNTY MONTGOMERY M				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE 54			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3916 W. UNDERWOOD ST.				d. STREET ADDRESS 3916 W. UNDERWOOD STREET 1			
3. NAME OF DECEASED (Type or print) Richard Bayly Winder				4. DATE OF DEATH Oct. 6, 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/24/1892	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY INVESTMENT BANKER		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME RICHARD BAYLY WINDER				14. MOTHER'S MAIDEN NAME CATHERINE STREET			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WORLD WAR 1 & 2 ---				17. INFORMANT MRS. JULIA P. WINDER, SAME AS # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis (c) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 75 hrs 2 Year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 1, 1959 to Oct 6, 1961 , that I last saw the deceased alive on Oct. 3, 1961 , and that death occurred at 1:35 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis T. Sharpe				ADDRESS (Street, city or town, state) 4105 Wisconsin Ave. Wash. D.C.			
PHYSICIAN'S NAME (Type) Francis T. Sharpe M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/10/61		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Shuler, Inc.				ADDRESS 1756 PA. AVE., N.W., D.C.		24a. REC'D BY REGISTRAR DATE OCT 10 '61	
				24b. REGISTRAR'S SIGNATURE Anthony S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12707

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NAME OF DECEASED JOHN DOE		DATE OF BIRTH JAN 1 1900	
SEX MALE		RACE WHITE	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		RESIDENCE 1234 MAIN ST, BALTIMORE, MD	
DATE OF DEATH JUL 15 1950		PLACE OF DEATH HOME	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. SMITH, M.D.		SIGNATURE OF WITNESSES J. H. SMITH, M.D. J. H. SMITH, M.D.	
DATE OF SIGNATURE JUL 15 1950		DATE OF SIGNATURE JUL 15 1950	
PLACE OF SIGNATURE BALTIMORE, MD		PLACE OF SIGNATURE BALTIMORE, MD	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day - DOA 12/30 Days		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Virginia		f. COUNTY Arlington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give real address) The Clinical Center 5721 Grosvenor Lane		3. NAME OF DECEASED (Type or print) HAZEL (NONE)		4. DATE OF DEATH Month Day Year October 19, 1961		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 10, 1913		9. AGE (In years last birthday) 47 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME David M. Albright		14. MOTHER'S MAIDEN NAME Daisy Welch		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage (Bilateral) Pulmonary Edema 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Multiple myeloma, Duodenal ulcer		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) January 30, 1961	
20f. (City or town) 1:10 AM		20g. (County) October 19, 1961		20h. (State) October 19, 1961		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 2, 1961 to October 19, 1961 that (I) (we) last saw the deceased alive on October 17, 1961 , and that death occurred at 1:10 AM on the causes and on the date stated above.		22a. SIGNATURE John C. Marsh M.D.	
22b. DATE SIGNED 10-20-61		22c. PHYSICIAN'S NAME (Type) John C. Marsh M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Rem-Burial		23b. DATE THEREOF Oct. 24, 61	
23c. NAME OF CEMETERY OR CREMATORY Shinnston Masonic		23d. LOCATION (City, town or county) Clarksburg, West Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Robert J. Murphy Address Carl, Va		25a. REC'D BY REGISTRAR DATE OCT 23 '61		25b. REGISTRAR'S SIGNATURE Arthur L. House	

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Belmont 20 days Arlington

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BAZEL (HOME) KIMF October 19, 1973

(1)

Female White November 10, 1973 17

Secretary Government West Virginia USA

David M. Albrecht Salary record

The Medical Record Not available The Clinical Center, Bethesda, Md, Maryland

Superintendent, National Institutes of Health, Bethesda, Md

Infected myeloma, recurrent, acute

October 21, 1973 x Secretary 21 October 20, 1973

October 21, 1973

John C. Marsh, M.D. The Clinical Center, National Institutes of Health, Bethesda, Md, 20892

October 21, 1973 x 11-20-73

Dr. J. C. Marsh, M.D. National Institutes of Health, Bethesda, Md, 20892

John C. Marsh, M.D.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11709 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11695

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY in 1b 4 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10,015 GRAYSON AVENUE				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 10,015 GRAYSON AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANK First MICHAEL Middle WISIECKI Last				4. DATE OF DEATH Month OCTOBER Day 28 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 23, 1911	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEERING AID				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT		11. BIRTHPLACE (State or foreign country) NEW YORK, N. Y.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME BLASE WISIECKI				14. MOTHER'S MAIDEN NAME FRANCES CAWALNA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. WW #2 096-10-9377		17. INFORMANT OLGA J. WISIECKA, 10,015 GRAYSON AVE., SILVER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease							INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/28/61	
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 31, 1961		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY, ARLINGTON COUNTY, VA.		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				24a. REC'D BY REGISTRAR OCT 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

THE
RECORD



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TO THE

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MONTGOMERY STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11710

CERTIFICATE OF DEATH

11696

1. PLACE OF DEATH a. COUNTY Montgomery M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 30 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14,101 Georgia Avenue				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 14,101 Georgia Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Joseph Almond Woodworth Sr. First Middle Last 5. SEX Male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH September 16, 1887 74 yrs. 9. AGE (In years last birthday) 74 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter-Retired 10b. KIND OF BUSINESS OR INDUSTRY Self employed 11. BIRTHPLACE (County & State, or foreign country) Washington D.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.				4. DATE OF DEATH October 13, 1961 Month Day Year 13. FATHER'S NAME Joseph A. Woodworth 14. MOTHER'S MAIDEN NAME Susie Waugh 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 577-26-7071 17. INFORMANT Mrs. Kate M. Woodworth Address 14,101 Georgia Avenue Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Heart failure DUE TO (c) Cardiomegaly due to aortic stenosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH Minutes 24 yrs. Years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from June 1959 to Oct 13, 1961 , that (I) (we) last saw the deceased alive on Oct 11, 1961 , and that death occurred at 7:00 AM , from the causes and on the date stated above.								22a. SIGNATURE Richard P. Delaney M.D. 22b. DATE SIGNED Oct 17 '61	
22c. PHYSICIAN'S NAME (Type) RICHARD P. DELANEY 22d. ADDRESS 4323 Harvard St, Silver Spring, Md								22e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur S. Huns	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/16/61 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 23d. LOCATION (City, town or county) (State) Montgomery County Maryland								24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Inc. 25a. REC'D BY REGISTRAR OCT 17 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01714

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11711 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
11697									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 29-3/4 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 12808 Meadowood Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Alice Strode Youngman					4. DATE OF DEATH Month Day Year 10-23-1961				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Yrs. Months Days Hours Min. 4-2-91				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Montgomery				
11. BIRTHPLACE (State or foreign country) Illinois					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Frank Strode					14. MOTHER'S MAIDEN NAME Louise Hendey				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. None				
17. INFORMANT Hospital records					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Brachio pneumonia with abscess (lobulated) DUE TO (b) 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Fracture left ankle									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor at home									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 10-22-1961									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home									
20f. (City or town) Silver Spring (County) Montgomery (State) MD									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-24-61									
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF 10/26/61									
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery									
22d. LOCATION (City, town, or country) (State) Washington D.C.									
23. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. ADDRESS 434 Georgia Avenue Silver Spring, Maryland									
24a. REC'D BY REGISTRAR OCT 25 '61									
24b. REGISTRAR'S SIGNATURE Arthur S. Hume									

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Frank J. Broschatt
FRANK J. Broschatt

M.D.

DATE SIGNED

100-3148
MAY 10 1961

(M)

contingency

Army

contingency general hospital

12803 Reservoir Drive

Youngman

Allen

Female

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Illinois

Rockwell

Police Agency

Franklin

Hospital records

Illinois

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